Leeds and York Partnership
NHS Foundation Trust

ANNUAL REPORT AND ACCOUNTS

1 April 2017
to
31 March 2018

Leeds and York Partnership NHS Foundation Trust

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Presented to Parliament pursuant to Schedule 7 paragraph 25 (4) (a) of the National Health Service Act 2006

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SECTION 1.1 – THE PERFORMANCE REPORT (Overview)

The purpose of the Overview Section is to provide a short summary setting out our purpose, key risks to the achievement of our objectives and how we have performed during the year.

1.1.1 THE CHAIR'S STATEMENT

This has been my first year at the Trust and I have spent much of it listening to staff, service users and carers, and our partners and learning about our services. Again and again I have been inspired by the passion our staff have for their work, their professionalism, dedication and energy. Our Trust values are Integrity, Simplicity and Caring, and these are demonstrated in abundance every day. However, these are difficult times for the NHS, and we are also facing many challenges.

We start every Board meeting with an opportunity to hear about the experience of service users, carers or members of staff. This discussion reminds us of the purpose of this organisation and of the reality of the day to day challenges we all face in trying to deliver services to the best of our ability within our financial limitations.

A memorable session last January was led by a manager, a matron and a health care support worker from the Becklin Centre. They talked to us about a topic discussed often; delayed transfers of care. However, rather than tell us about numbers, problems in our processes or those of our partners, they gave three examples of how this matter impacts on patients and their families. How it feels to be a 'bed blocker', and how demoralising it can be for both patients and staff when the system fails to respond to complex and challenging need. This session was so powerful because in the midst of our focus on finances, performance management, regulation and other matters, it is easy to forget about the human side of our services, and the emotional impact on our staff and those they care for. In their words and actions, these staff demonstrated real compassion and a quest for solutions. It was both humbling and inspiring to hear.

This year the Board agreed our strategic vision and underpinning implementation plans. The plans cover workforce, estates, information technology, clinical services and quality. They represent a huge amount of work, detailed planning and a creative ambition for the future provision of services for people with mental illness and learning disabilities in Leeds and York. They will provide a focus for the Board during 2018/19, the first year for implementing these three year plans.

We had an inspection from the CQC this winter and they visited a number of our services in addition to reviewing the leadership of the Trust. We were delighted they rated our supported living service as outstanding for care, and rated many of our services as good. We were also pleased to be rated good for being 'well-led'. Our overall rating of 'requires improvement' means there is more to do to build on much of the good practice in place in some of our services, to ensure consistency in high standards across all our services. Work is underway to address these matters and we will welcome the inspection team back next year to review our service improvements.

We work closely with many partners in delivering mental health and learning disability services to people in Leeds and York. We are also taking an active role in the wider collaborative systems across West Yorkshire and Harrogate, working with other mental health providers to improve services. I would like to take this opportunity to thank all of our partners within the NHS, local authorities, third sector and education sector. We look forward to continuing this work to deliver sustainable improvements in the coming year.

I am extremely grateful to the Council of Governors for their commitment and continued work in the Trust. This year has seen a number of changes in welcoming new governors and saying goodbye and thanks to a number of long serving governors too. Governors have such an important role in holding the non-executives to account, and in representing the views of the public, staff, service users and carers. We have done some important work to strengthen their contribution and to enable them to carry out their roles effectively.

The Board has seen some changes, and we welcomed two new non-executives, and two new executive directors. I would like to take the opportunity of thanking their predecessors for all their dedication and

support to the Trust in recent years. We commissioned a review of our governance arrangements and have put in place a stronger, clearer system to ensure the organisation is well-led now and in the future.

In the media, the NHS often generates negative headlines which tell of unprecedented demands and pressures, especially during the winter months. This year was no exception and I was hugely impressed by the dedication and resilience of our staff during one of the coldest winters for many years. Staff across our services worked hard to provide support and care for so many of our service users and their families, and the Board is very grateful for their efforts.

In 2018, we celebrate the 70th anniversary of the NHS and there will be many events and activities across the Trust to mark this significant year. We have some truly impressive and unique activity in this Trust which recognises the value of supporting positive mental health and tackling the stigma of mental illness. These include arts, creativity, learning, and capturing the stories of service users to provide insight and an authentic voice to improving our services.

As we look to next year, we will no doubt continue to face pressures across our services, but we have strong foundations in place, and staff who live and demonstrate our values every day. We are focused on continuing to improve and develop our service to ensure excellence for all our service users.

Prof Sue Proctor
Chair of the Trust

1.1.2 THE CHIEF EXECUTIVE'S INTRODUCTION

I am delighted to present our annual report for 2017/18 as Chief Executive of Leeds and York Partnership NHS Foundation Trust.

This past year has been extremely busy in the Trust, like the rest of the health and social care sector.

In November 2017, the Board approved our new 5 year strategy, which put our values at the heart of all we do. We have completed a full overhaul of our governance arrangements in the Trust, strengthening our leadership, Board to ward visibility and assurance. This was reviewed as part of the CQC inspection and I am pleased to report we have now improved our rating of well-led to 'good'.

We also saw continued improvement in our staff survey results this year which is testament to the hard work of all our staff, managers and leaders in the organisation. We work in times of increased demand, shortages of staff and our workforce is our biggest asset, which is why we have ambitions to be the employer of choice. Our Workforce and Organisational Development Strategic Plan was the first of our plans to be endorsed by the Board and along with our plans for quality, estates and IT is a key enabler to delivering on our clinical strategy and our overall Trust strategy.

Our values are now being embedded across the organisation with the launch of a toolkit developed following a series of engagement events we held throughout the year.

- We have integrity
  We treat everyone with respect and dignity, honour our commitments and do our best for our service users and colleagues.

- We keep it simple
  We make it easy for the communities we serve and the people who work here to achieve their goals.

- We are caring
  We always show empathy and support those in need.

Our values came through loud and clear during our recent CQC inspection with staff being described as kind and compassionate, and consistent feedback from service users and carers that they are treated with dignity and respect. Whilst it was disappointing that our overall rating remained as 'requires improvement' this time, we need to celebrate that over 85% of our services are now rated as good or outstanding.

Despite increased and on-going risks to our financial position, we have delivered on the control total set by our regulator, NHS Improvement (NHSI), and have maintained the best score possible for our financial performance. The Trust's financial performance has been given a score of 'one'. Overall, the Trust is scored as a 'two', (targeted support) because of our 'requires improvement' CQC rating.

Mental health, learning disabilities and the concept of parity of esteem continue to be high up on the political and national agenda. We submitted a refresh of our operational plan which responds to and aligns our clinical strategy with the requirements of the planning guidance and our local Sustainability and Transformation Partnership (STP) footprints of West Yorkshire and Harrogate, and Humber Coast and Vale.

We have continued to develop our alliance with Bradford District Care NHS Foundation Trust, Leeds Community Healthcare NHS Trust and South West Yorkshire Partnership NHS Foundation Trust as the lead providers of mental health and learning disability services in West Yorkshire and Harrogate. We agreed to formalise our arrangements with the creation of a Committees in Common.

We were successful in our bid to lead on a new care model for Eating Disorders for West Yorkshire and Harrogate which went live on the 1st April 2018. We were also successful in securing additional investment for liaison psychiatry and have been commissioned to deliver a new service for complex mental health provision for veterans for the North of England. Collaboration and partnership working will continue to be a key focus of our work in the year ahead.

Finally, I would like to reiterate my thanks and appreciation to all our staff, service users and carers for their continued hard work and their on-going commitment, honesty and challenge. I have the privilege of meeting with many of them throughout the year and regularly receive direct contact and feedback, both on areas of success as well as areas where we have more work to do. We have so much to be proud of and I want us to build on the work we do well in the year ahead, learning and seeking feedback in order to improve where we need to. We are all passionate ambassadors for mental health and learning disabilities. Through living our values we are committed to making a difference.

Dr Sara Munro
Chief Executive

1.1.3 ABOUT OUR TRUST – A BRIEF HISTORY AND STATUTORY BACKGROUND

As part of the NHS and Community Care Act (1990) the Leeds Community and Mental Health Services Teaching NHS Trust was formed on 1 February 1993. This was a self-governing trust providing community, mental health and learning disability services within the Leeds metropolitan area. In 2002 the community services previously provided by the NHS Trust transferred to the PCTs in Leeds, and the Trust was renamed the Leeds Mental Health Teaching NHS Trust; providing only mental health and learning disability services.

On 1 August 2007 NHS Improvement (formally Monitor) authorised us as a foundation trust, and we were formed as the Leeds Partnerships NHS Foundation Trust under the NHS Act 2006. As a foundation trust we continue to provide mental health and learning disability services have freedoms to act which NHS trusts don't.

A further development for our Trust was the acquisition of mental health, learning disability and substance misuse services from NHS North Yorkshire and York and NHS England on 1 February 2012. To reflect the new geographical area in which services were provided we became the Leeds and York Partnership NHS Foundation Trust. However, the services commissioned by NHS North Yorkshire and York transferred to Tees, Esk and Wear Valleys NHS Foundation Trust on 1 October 2015. The Trust still provides Tier 4 and deaf CAMHS and Low Secure Forensic services in York which serve a regional population base and are commissioned by NHS England.

1.1.4 STATEMENT OF PURPOSE AND ACTIVITIES OF THE TRUST

We are a provider of specialist mental health and learning disability services. As a teaching trust with strong links to local universities we have a reputation as a centre of excellence for teaching, research and development, partly attributable to the national profiles of a number of our clinicians.

We are also the principal provider of secondary mental health and learning disability services in the city of Leeds. We have developed robust relationships with service users, carers and our partners in the NHS, Local Authorities and third sectors.

We provide services to approximately 781,000 adults in the Leeds areas and specialist services and accept referrals from across the UK. We operate from 123 dispersed sites and employ approximately 2,500 staff and 450 bank staff.

Clinical services are currently delivered across two service directorates:

Leeds Care Group	Providing adult services and is commissioned by the Leeds CCG
Specialist and Learning Disabilities Care Group	Providing mainly NHS England specialist services but with some CCG and Local Authority commissioned services such as learning disabilities

The Care Quality Commission (CQC) asks us to list our services within a set of pre-determined categories. Using these categories the regulated activities that we are registered to provide are as follows:

- Treatment of disease, disorder or injury
- Nursing care
- Assessment or medical treatment for persons detained under the Mental Health Act
- Diagnostic and screening procedures
- Personal care.

More information about the work of the directorates can be found in Part A section 2.2.1 of this Annual Report.

1.1.5 OUR STRATEGY

In November 2017 we launched our reimagined Trust Strategy *Improving health, improving lives*, which describes what we want to achieve over the next five years (to 2023) and how we plan to get there. The strategy is designed around the three key elements of delivering great care; a rewarding and supportive workplace; and effective and sustainable services.

Our strategic intent set out in our Trust Strategy (2018-2023) and one-year Operational Plan (2018-2019) and has been fully aligned with the key themes within national and local strategies and the challenges and opportunities we see ahead over the next one to five years. We have continued to work alongside commissioners and providers both locally and regionally to develop integrated strategic objectives and plans.

1.1.5.1 Our goals, strategic objectives and priorities

Our new organisational strategy used a crowdsourcing approach to reimagine our vision, values and strategic objectives. Through extensive staff engagement the organisation developed and agreed a new vision and ambition; three simple objectives that describe the outcomes we aspire to; and the values we will work to. They are the three things we believe will help us achieve our vision and which we are passionate about realising. We have deliberately kept them simple so all our staff can keep a clear focus on them every day and in everything they do.

Our strategy describes the strategic objectives that we have set ourselves to achieve over the next five year that will enable us to deliver on our ambition. For each objective we have a series of priorities for action for achievement by 2022/23. All our priorities will be tracked through our governance framework to make sure we are on course to achieve them.

A headline summary of our new strategy on a page can be found below.

Table 1.1A – Our Trust strategy

Purpose	Improving health, Improving lives	
Vision	To provide outstanding mental health and learning disability services as an employer of choice	
Ambition	We support our service users and carers, our staff and the communities we serve to live healthy and fulfilling lives. We want to achieve our personal and professional goals; to live our lives free from stigma and discrimination; and to improve the lives of people with a learning disability and mental ill health	
Our Values		
We have integrity We treat everyone with respect and dignity, honour our commitments and do our best for our service users and colleagues.	**We keep it simple** We make it easy for the communities we serve and the people who work here to achieve their goals.	**We are caring** We always show empathy and support those in need.
Our Strategic Objectives		
1. We deliver great care that is high quality and improves lives.	2. We provide a rewarding and supportive place to work.	3. We use our resources to deliver effective and sustainable services.

1.1.5.2 How we have involved our governors

Our new five-year Trust strategy was developed with our staff, governors, members and partners. A sub-group of the Council of Governors helped shape our new organisational strategy, reporting its recommendations to both the Council of Governors and the Board of Directors.

The Council of Governors receive regular reports on the progress we are making with our strategy and importantly, the impact this is having for service users, carers and staff.

1.1.5.3 Our strategic plans

To support the delivery of our overarching strategy our Board agreed five 3-year strategic plans. These are for Workforce and Organisational Development; Quality; Clinical Services; Health Informatics; and Estates. These have been signed off by our Board and priorities for 2018/19 identified to support delivery of the plans. More information about the priorities we have agreed can be found on our website.

1.1.6 OUR VALUES AND BEHAVIOURS

Our values and behaviours describe what attitudes and behaviours we believe are important in achieving our purpose. A key part of our strategy redevelopment has focused on the values and behaviours our staff are committed to deliver. Our charter of values is set out below.

Table 1.1B – Our values and behaviours

Our values	Behaviours that uphold our values
We have integrity We treat everyone with respect and dignity, honour our commitments and do our best for our service users and colleagues.	• We are committed to continuously improving what we do because we want the best for our service users. We consider the feelings, needs and rights of others. • We give positive feedback as a norm and constructively challenge unacceptable behaviour. • We are open about the actions we take and the decisions we make, working transparently and as one team with service users, colleagues and relevant partner organisations.
We are caring We always show empathy and support those in need.	• We make sure people feel we have time for them when they need it. • We listen and act upon what people have to say. • We communicate with compassion and kindness.
We keep it simple We make it easy for the communities we serve and the people who work here to achieve their goals.	• We make processes as simple as possible. • We avoid jargon and make sure we are understood. • We are clear what our goals are and help others to achieve their goals.

1.1.7 PRINCIPAL RISKS FOR THE ORGANISATION

Key risks for the organisation are those that have been identified as strategic risks on the Strategic Risk Register. In summary these described as follows:

- Due to an inability to align our workforce capacity to planned models of care, there is a risk that we are unable to deliver high quality, evidence based, person centred care
- We are unable to maintain compliance with regulatory requirements relating to the quality and safety of our services due to a failure to provide care in line with national standards and best practice.
- Due to inadequate systems to support continuous learning, improvement and innovation, there is a risk that our services deliver poor outcomes for service users
- We are unable to maintain effective, productive relationships with key external stakeholders, with the result that we are unable to work successfully with partners to support innovative care and exceptional outcomes for service users
- If we cannot produce and effectively use information about our services to support the operation of our governance structures, there is a risk that there will be a lack of confidence in our management information and that we will be unable to ensure the safety of our services
- We are unable to deliver an effective and attractive programme of training and development opportunities for our staff due to inadequate capability and capacity, corporately and within care services

- As a result of a culture of blame which does not foster a psychologically safe environment for our staff we are unable to reduce patient harms or provide a positive experience for our service users
- A lack of financial sustainability results in us having insufficient funds to sustain and develop our services and invest in high quality outcomes for our service users
- Due to inadequate, inflexible or poorly maintained estates and facilities we are unable to provide a safe and positive environment for service users and staff
- As a result of insecure, inadequate or unstable information technology systems and infrastructure, the quality and continuity of our services is compromised.

Each of these risks has an identified executive director and management lead. These risks will be managed through the risk management, risk register and operational planning processes. They will be reported to the Executive Risk Management Group and the Board through the BAF.

Behind each risk is a detailed risk assessment which sets out the controls and mitigations.

1.1.8 GOING CONCERN STATEMENT

After making enquiries, the directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason they continue to adopt a going concern basis in preparing the accounts.

SECTION 1.2 – THE PERFORMANCE REPORT (Performance Analysis)

1.2.1 MEASURING PERFORMANCE

We have NHS Improvement targets, NHS Standard contract requirements, national and local Commissioning for Quality and Innovation (CQUIN) measures and locally agreed performance and quality measures with our commissioners (referred to in this section as targets and measures).

Each month, we produce a Combined Quality and Performance Report (CQPR) that brings together performance, activity, and quality, workforce and financial measures into one report for our Board meetings. This includes the requirements for monitoring performance through NHS Improvement's Single Oversight Framework as well as contractual and local metrics. Relevant sections of this report are shared with and discussed by our Board sub-committees. By bringing all these aspects of our organisation and care into one place, links can be made and risks identified which might impact on service user experience and our performance.

During 2017/18, we developed and implemented our Governance, Accountability, Assurance and Performance Framework (GAAP), which sets out our performance reporting process across the whole of the organisation from floor to Board and vice versa.

We have focused on putting in place a performance framework that delivers reporting for our team and service managers as well as the high level CQPR reporting to Board. Reports are issued monthly highlighting key performance, quality and workforce metrics. These metrics are discussed in service performance meetings, operational delivery groups and at the monthly Performance, Information and Data Quality Group (PIDQG) meetings.

PIDQG also focuses on the definitions that sit behind the measures and whether reporting is being affected by data quality or completeness providing assurance to the organisation about the robustness of the data being used for analysis and decision making. In addition, Commissioning for Quality and Innovation (CQUIN) reports are produced in accordance with the Standard Contract reporting timescales.

There are identified leads for each target and measure and they are responsible for ensuring reports are submitted on time and that all relevant actions are completed to achieve performance. Where agreed targets are not met exception reports are produced by the relevant lead or service explaining how they will address the issue and move towards achievement. Where required contractually, Remedial Action Plans are also produced for the commissioners.

We also have regular dialogue with our commissioners and have a reporting schedule to submit performance and quality information to them. We meet on a regular basis (monthly and quarterly) and have a set agenda which addresses all aspects of performance and quality.

1.2.1.1 Areas of focus

Month on month we continue to perform well against all our contractual and local targets.

Table 1.2A – Our contractual and local targets

Measure	Target	At Q1 2017/18	At Q2 2017/18	At Q3 2017/18	At Q4 2017/18
Leeds CCG					
Bed occupancy rates for inpatient services (Leeds contract)	94-98%	97.88%	97.92%	99.04%	98.87%
Percentage of people with a crisis assessment summary and formulation plan in place within 24 hours (Leeds contract)	95%	97.77%	98.75%	97.55%	97.53%
Waiting times for Community Mental Health Teams for face to face contact within 14 days (Leeds contract)	80%	69.81%	73.42%	75.86%	79.12%
Waiting times access to memory services; referral to first face to face contact within 8 weeks (Leeds contract)	90%	76.24%	79.83%	84.24%	90.48%
Memory services – time from referral to diagnosis (Leeds contract)	50%	38.26%	50.56%	49.49%	70.90%
Proportion of in scope patients assigned to a cluster (Leeds contract)	Q1 – 95% Q2 – 95% Q3 – 90% Q4 – 90%	88.85%	88.24%	89.26%	89.54%
Referral and receipt of a diagnosis within the Leeds Autism Service (Leeds contract)	80%	65.08%	71.88%	47.73%	20.93%
Timely access to a mental health assessment by the ALPs team in the LTHT emergency department (within 3 hours) (Leeds Contract)	90%	90.57%	85.74%	84.84%	88.14%
Timely access to mental health assessment under S136; % within 3 hours (Leeds contract)	No target	37.95%	32.61%	33.13%	31.06%
Timely communication with GPs Notified in 10 days (Leeds contract)	80%	62.37%	71.68%	68.35%	60.53%
NHS England					
CAMHS use on admission of HoNOSca and CGAS as effective tools for improving outcomes (NHS England)	95%	100.00%	100.00%	100.00%	100.00%

Measure	Target	At Q1 2017/18	At Q2 2017/18	At Q3 2017/18	At Q4 2017/18
CAMHS use on discharge of HoNOSca and CGAS as effective tools for improving outcomes (NHS England)	95%	88.89%	100.00%	100.00%	100.00%
Gender Identity Service average waiting time to first offered appointment (NHS England)	No target	540	490	445	375
Gender Identity Service waiting list (NHS England)	No target	1,029	955	894	868
HCR20 & HoNOS secure within 3 months of admission	95%	70.00%	72.73%	42.86%	85.71%
HCR20 & HoNOS secure (LOS>9months)	95%	95.00%	86.11%	75.00%	84.62%
Standard NHS contract					
Data completeness - ethnicity (NHS Standard contract)	90%	79.02%	80.46%	81.84%	84.98%
Dataset completeness - NHS number	99%	96.39%	96.61%	98.69%	98.77%
Incidents reported within 48 hrs from incident identified as serious (contract)	100%	100.00%	100.00%	85.71%	100.00%
Never Events (national)	0	0	0	0	0
NHS Safety Thermometer harm free care	95%	97.86%	97.90%	97.95%	98.92%
Other reported indicators					
Care Programme Approach formal reviews within 12 months (Previously reported to Monitor, not requested as part of the SOF)	95%	90.56%	92.95%	93.57%	91.74%
Delayed Transfers of Care (Previously reported to Monitor, not requested as part of the SOF)	7.5%	3.52%	5.07%	11.00%	12.55%
Healthcare associated infections – C.difficile	0	0	0	0	0
Healthcare associated infections – MRSA	0	0	0	0	0

The Trust meets regularly with its commissioners to review performance against the key metrics and action plans are put in place for any metric falling below standard. The reasons for underperforming are discussed and challenged both internally and with commissioners to ensure that all possible steps are being taken to improve. Factors outside of our control such as the higher than anticipated referral numbers in the Gender Identity service are taken into account alongside reasons that can be more easily influenced such as real time data entry into clinical systems or differing performance across similar teams within the organisation to ensure that a rounded picture of performance is achieved.

With regard to our financial performance, at the end of 2017/18 we marginally exceed our regulatory control total but there remain some significant areas of concern and on-going pressures which may impact on the forward financial plan for 2018/19.

Our key financial metrics are set out in the table below. A more detailed financial commentary can be found in Part A Section 1.2.2 of this Annual Report.

Table 1.2B

Key metrics	Year to date		
	Plan	Actual	Trend
Single Oversight Framework finance score	1	1	⟷
Income and expenditure position (£000s)	3,679	3,822	⟷
Recurrent CIP (£000s)	3,321	2,787	⟷
Non-recurrent CIP (£000s)	2,664	0	⟷
Cash (£000s)	47,885	52,424	↑
Capital (£000s)	4,910	1,742	↓

In January 2018 we received an inspection from the CQC. The report was issued and said staff were "caring and compassionate during their interactions with patients" and that "feedback from patients confirmed that staff treated them well and with kindness, compassion and respect." It also said that "patients were positive about the care and treatment they received and felt involved in the decision-making" and that "staff involved carers and others close to patients in decisions about the care and treatment provided by the service."

The report showed that 85% of the Trust's services are now rated as either good or outstanding. However; there were still a number of issues to resolve including three services rated as 'Requires Improvement' alongside some actions the Trust needs to take centrally. As such the Trust has been rated 'Requires Improvement' overall.

The Trust was given the following overall ratings by the CQC:

Table 1.2C

Are services safe?	**Are services effective?**	**Are services caring?**	**Are services responsive?**	**Are services well-led**	**Overall**
Requires improvement	Requires improvement	Good	Good	Good	**Requires improvement**

Whilst the CQC raised a number of risk areas, there were no incidences or evidence of service users receiving poor treatment or inappropriate care. There are however a number of areas we still need to address which has meant our overall rating has stayed at requires improvement. This was disappointing as services have worked very hard and made so many improvements, many of which have been recognised in the CQC's report.

We are looking at the actions we need to take to address the findings and will put these in place as quickly as possible in time for our next inspection.

More information about our performance against our targets and measures can be found in Part A section 2.7 of this Annual Report.

1.2.2 FINANCIAL PERFORMANCE

1.2.2.1 Overview

The Trust's financial plan for 2017/18 was set to underpin the overall strategic objectives and support the delivery of the operational plan. It was also set in the context of the national strategic position with an imperative to reduce the overall deficit of NHS provider sector. To meet this aim the Trust was set an Income and Expenditure "Control Total" surplus target. The surplus target was equivalent to 2% of turnover, which the Board agreed would be stretching but achievable, assuming some non- recurrent savings.

The Trust's plan and actual performance is highlighted in the table below, showing the key areas which we measure and assess our overall financial performance. The table demonstrates overall a very solid financial performance by the Trust, building on good performances in previous years and helping to maintain an underlying stable position.

Table 1.2D

Plan		**Outturn**	
Income and expenditure surplus	£3.7m (2.4%)	Income and expenditure surplus	£3.8m (3.5%)
Capital expenditure	£4.9m	Capital expenditure	£1.7m
Cost improvement / efficiency	£4.7m	Cost improvement / efficiency	£2.7m
Agency ceiling	£5.7m	Agency ceiling	£4.5m
Use of resources score	1	Use of resources score	1

The use of resources score is the overall assessment used by NHS Improvement, our regulator. It is based on five key financial metrics which are shown in the table below;

Table 1.2E – Use of Resources Metric

Year ending 31 March 2018	**Score**	**Risk rating category**	**Weighting**
Capital service capacity	2.39	2	0.4
Liquidity	111 days	1	0.2
Income and expenditure margin	3.5%	1	0.2
Variance in income and expenditure margin	1.0%	1	0.2
Agency spend	-21.8%	1	0.2
Use of resource metric score		**1**	**1.2**

An overall score ranging from 1 (highest performance / lowest risk) to 4 (lowest performance / highest risk) is calculated based on these five metrics.

Capital service capacity
This metric measures our ability to service long-term debt. This is important for the Trust as we have high levels of debt linked to our Private Finance Initiative (PFI) assets.

Liquidity
This measures the number of days the Trust can operate and pay day-to-day expenses, after accounting for all outstanding current liabilities. The Trust is in a strong position with this metric currently at 111 days (the prior year was 97 days). This is mainly due to the level of cash balances.

Income and expenditure margin
This measures the overall surplus as a percentage of operating income. A good minimum surplus is around 1-2% in order to generate cash for reinvestment. The Trust's overall level of income and expenditure surplus was higher than planned, mainly as a consequence of additional unplanned non-recurrent income that was received through the Sustainability and Transformation Fund (STF). This was

due to the Trust achieving its financial performance target and as a consequence receiving a further £1.4m income, generating a headline surplus of £5.4m. A technical adjustment based on the downward revaluation of our PFI assets (an impairment) reduced the net surplus to £3.8m as shown in the table below.

Table 1.2F

Year ending 31 March 2018	Plan £m	Actual £m	Variance £m
Surplus (pre STF)	2.664	2.878	0.214
Sustainability and Transformation Fund (STF)	1.015	2.502	1.487
Surplus (pre impairments)	**3.679**	**5.379**	**1.701**
Impairments	0	(1.557)	(1.557)
Reported surplus	**3.679**	**3.822**	**0.143**

Income and expenditure variance
This measures the gap between the planned margin and the actual margin. The Trust over-achieved on the plan so this equates to a good performance.

Agency ceiling
This metric was introduced in 2017/18 to provide a focus on reducing the excessive cost burden of spending on agency staff nationally. Through a series of measures the Trust reduced spending on agency from £4.8m (2016/17) to £4.5m in 2017/18. The Trust performed well against a maximum ceiling (target maximum spend) of £5.7m.

1.2.2.2 The Statement of comprehensive income (year-on-year)

The statement of comprehensive income shows a surplus of £3.8 million for the year ended 31 March 2018 (compared to £5.2m in the previous year). As in the previous year, the financial performance reflects a range of non-recurrent factors and exceptional items. These include unutilised reserves and provisions; technical adjustments; additional in-year non-recurrent funding for service changes; and developments, some of which resulted in a level of slippage. It also includes the STF funding of £2.5m, as noted above. After taking into account all of these, the underlying financial position of the Trust is broadly break-even with an underlying risk around Out of Area Placements (OAPs) costs. This is a shared issue and risk that we continue to work with our commissioners to resolve.

Operating income
Our income for the year increased to £156.5 million (£153.3 million in 2016/17), which reflects movements in tariff inflation and the impact of recurrent and non-recurrent funding changes across the years. Income received in respect of service user care activities is predominantly received on a fixed block basis.

Operating expenses
The total operating expenses for the year was £146.6 million (£143.9 million in 2016/17), which is a net increase of just under 2%. Staff costs are our single largest operating expense and this increased by 1.5% in the year. The Trust made a positive material impact on agency spend during the year as noted above. Expenditure on the purchase of healthcare from non-NHS bodies increased to £6.6 million during the year (£4.7 million in 2016/17) mainly as a consequence of increasing numbers of OAPs.

Cost Improvement Plans (CIPs)
Each year we are required to meet a level of efficiency savings through the cost improvement programme. Combined cost savings delivered £2.8m (around 1.8% of operating expenses less PFI costs) in the year.

1.2.2.3 Capital expenditure

The Trust planned to spend £4.9m on capital improvements in 2017/18. However during the year, the plan was scaled back as it became clear that the initial plans could not be fully delivered, due to some key dependencies on external stakeholder decisions in relation to longer term service plans. Overall we delivered a level of investment of £1.7m, which was lower than the previous year (£3.5m) and all linked to the key priorities and risks identified by the Trust. The main estate projects included some improvement works on our dementia wards, phase one of a major programme of refurbishments linked to anti-ligature risks across the estate and an expansion of the bed base from 6 to 8 on our perinatal inpatient unit. Information technology investment included completing the e-prescribing system implementation; a large-scale programme to roll out smartphone devices; and other remote access technology to support agile working for community-based staff. Initial work also commenced on the project to re-procure a fully electronic patient record, which will be a major scheme over the next two years.

1.2.2.4 The statement of financial position

The summary of the Trust's overall value shows a net increase in taxpayers' equity of £5.0 million to £72.5 million as at 31 March 2018. This reflects the impact of the surplus generated in the year and the net impact of asset disposals and revaluations. Working capital (current assets less current liabilities) has increased by £6.4 million, of which, the net cash increase was £4.7 million. The surplus cash held at the end of the year was deposited with HM National Loans Fund. It is our policy to deposit any temporary surpluses in cash in low-risk deposit accounts with either United Kingdom commercial clearing banks or the HM National Loans Fund.

1.2.2.5 Future financial outlook and risks

The Trust has prepared an operational financial plan for 2018/19, which supports the delivery of the objectives for the year. Due to the significant financial pressure that the NHS provider sector, in aggregate, remains under, individual organisations have again been asked by the regulatory bodies to deliver the most challenging stretching position possible. The Board of Directors has agreed a £3.3 million surplus plan for 2018/19 which includes STF funding of £1.4 million. This requires an overall cost improvement plan of around 2% (£2.9m) and non-recurrent additional savings of £1.9m, which we aim to achieve via disposals of surplus estate.

Recognising the wider financial challenges of the NHS and social care, the Trust's financial strategy remains focused on supporting the organisation to achieve its goals and maintain a strong stable position, which minimises financial risk. We fully recognise the balance between financial sustainability, service quality and improvement, with the emphasis being to work more collaboratively to ensure system-wide sustainability. The Trust is well placed to support the broader agenda and is in a stable financial position.

1.2.2.6 Our exposure to financial risks

Price risk
We have a relatively low exposure to price risk. This is for three main reasons. Firstly, salary costs are the single biggest component of our costs and for 2017/18 our financial plans reflect the nationally agreed pay award of 1%. With regard to non-pay our plans assume a similar level to the projected rate of increase in the consumer price index.

Secondly, income assumptions are set out each year through the business and planning arrangements for the NHS, as mandated by the Department of Health. Assumptions made regarding inflationary / deflationary changes have been assumed to be extremely challenging in the future. Finally, most income is received on a 'block contract' basis rather than 'pay as you go' and it is unlikely for the significant part of our income that this will change quickly.

Credit risk
This is minimal as the majority of our customers are public sector organisations, in particular NHS organisations.

Liquidity risk
Liquidity risk is felt to be low. This is because operating costs are incurred primarily through legally-binding contracts for services provided to clinical commissioning groups and NHS England, which in turn are financed from money received from parliament. Assumptions about future income have been revised to take into account the new market conditions.

Cash-flow risk
The main sources of income and expenditure are extremely predictable. The Trust is forecast to retain significant cash and other liquidity resources for the foreseeable future. Cash-flow risk is therefore felt to be low due to the adequate level of cash reserves; and the Trust not having sought a working capital loan facility because we have sufficient working capital. The Trust has modified its capital expenditure plans and has a robust approach to investment appraisal including risk issues.

1.2.3 CORPORATE SOCIAL RESPONSIBILITY

1.2.3.1 Human rights

Our Trust respects and abides by all human rights legislation. The human rights principles of fairness, respect, equality, dignity and autonomy are detailed within our organisational values. They underpin our strategic objectives and our policies and procedures. Minimum standards are set out within our Equality, Diversity and Human Rights procedure and adherence to these standards and principles are monitored through our governance structure.

1.2.3.2 Sustainability report

1.2.3.2.1 Introduction

As an NHS organisation, and a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means being smart with our money, making efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health both in the immediate and long-term even with the pressures of the rising costs and reducing availability of natural resources.

Demonstrating that we consider both our social and environmental impacts ensures that the legal requirements of the Public Services (Social Value) Act (2012) are met. We acknowledge this responsibility to our patients, local communities and the wider environment by working hard to minimise our footprint. As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the total carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020.

1.2.3.2.2 Where have we been?

Our Trust was formed on 1 February 2012 following the merger of Leeds Partnership NHS Foundation Trust (LPFT) with the mental health, learning disability and substance misuse services of NHS North Yorkshire and York (NY&Y). We grew from 28 occupied sites to nearly 60, almost doubling our floor space and increasing whole time equivalent employees (WTE) significantly. To date there has been a considerable drive to rationalise our estate and in terms of occupied sites and WTE employees, numbers are almost back to our 2007/08 levels. The table below shows comparative figures.

Table 1.2G – Gross internal floor space to whole time equivalent staff

	2007/08	2013/14	2014/15	2015/17	2016/17	2017/18
Gross internal floor space (m_2)	58,599	105,692	105,692	105,692	29632	59,632
Number of staff (WTE)	2,268	2,955	2,929	2,436	2,375	2,543

As a result of the continuing rationalisation detailed above, and other carbon accounting complexities introduced by the original merger a line has to be drawn under the original Carbon Management Plans produced individually by both LPFT and NY&Y which both included carbon reduction targets that were not realised.

Leeds and York Partnerships NHS Foundation Trust's Carbon Management Plan (CMP) was established following participation in an ambitious programme in 2009 in partnership with the Carbon Trust in order to realise substantial carbon and cost savings. Committing the Trust to a target of reducing it's 2007/2008 CO2 emissions by 25% rather than 10% by 2015. NY&Y PCT also had a CMP in place that was developed in 2010, with a target to reduce CO2 emissions from its operations by 25% by 2014/15 from 2008/09 levels.

As part of our continued efforts to meet the 2020 reduction target we have chosen 2013/14 as our new base year and calculated all available emissions for LPFT and NY&Y resulting in a total footprint for LYPFT. As part of this work we also rebased the baseline emissions for LPFT & NY&Y, due to the government's removal of the 5 year grid electricity rolling average and recalculated the 2007/2008 baseline emissions for LPFT, using more accurate data.

1.2.3.2.3 Policies

Our Sustainability Policy has been completely revised this year to ensure its continuing suitability to meet the requirements of our forthcoming certification to ISO 14001:2015 standard for environmental management systems.

The policy is now able to provide a consistent framework under which to set targets and ensure the policy commitments are endorsed and actively supported by senior managers. It also serves as a means for the communication of the Trust's commitments to continually improve its environmental performance and engage all relevant interested parties in the identification of environmental risks and opportunities.

Our new policy supports the Trust in adopting the principles of sustainable development and achieving the improvements that will be detailed under our Sustainable Development Management Plan (SDMP).

In order to embed sustainability within our business it is important to explain where in our process and procedures sustainability currently features. This is set out in the table below.

Table 1.2H

Area	Is sustainability considered?
Travel	Yes
Business cases	No
Procurement (environmental)	No
Procurement (Social impact	No
Suppliers' impact	No

One of the ways in which we measure our impact on corporate social responsibility is through the use of the Good Corporate Citizenship (GCC) tool. The last time we used the GCC self-assessment was in January 2015, scoring 23%. As an organisation that acknowledges its responsibility towards creating a sustainable future, we help achieve that goal by running awareness campaigns that promote the benefits of sustainability to our staff.

Climate change brings new challenges to our business both in direct effects to the healthcare estates, but also to patient health. Examples of recent years include the effects of heat waves, extreme temperatures and prolonged periods of cold, floods, droughts etc. We have identified the need for the development plan for future climate change risks affecting our area. We are currently compiling and assessing the social and environmental impacts for the Trust.

1.2.3.2.4 Partnerships

The NHS policy framework already sets the scene for commissioners and providers to operate in a sustainable manner. Crucially for us as a provider, evidence of this commitment will need to be provided in part through contracting mechanisms. More information on these measures is available here: www.sduhealth.org.uk/policy-strategy/reporting/organisational-summaries.aspx.

1.2.3.2.5 Our performance

Due to the changes of the Trust's organisational boundary over previous years, there are some reporting complexities and challenges that we continue to work to improve. Particular limitations in this year's report include:

- The energy spend from our PFI sites (which accounts for 46% of total consumption) not currently being available.
- Water Consumption figures and spend for PFI, NHS Property Services or private leased sites not being available. It should also be noted that water use and treatment volumes have not been included in scope 3 emissions data.

70% of our occupied floor space comprises buildings that we do not own and do not directly control. This does present the Trust with some challenges in both acquiring accurate scope 3 data and influencing efficiencies. Due to these challenges we have again chosen to present only core data for this year's report, which includes our Scope 1 and Scope 2 emissions, and restricting our scope 3 emissions to business travel only.

The tables below show the breakdown of our energy consumption based on building / site ownership and compare this year's consumption with that of 2016/17.

In 2014 the Sustainable Development Strategy outlined an ambition to reduce the carbon footprint of the NHS by 28% (from a 2013 baseline) by 2020. The following results demonstrate how we have supported this ambition.

1.2.3.2.6 Energy performance

Currently 0% of our purchased electricity comes from renewable sources and this is something we will be looking to investigate in the future.

Our total energy consumption continues to see an overall reduction on last year's figures of 6%, in spite of a 7% increase in staff numbers and increased energy use at our NHS Property Services owned sites.

Table 1.2I

Total annual electricity and natural gas consumption 2017/18		
Ownership	**kWh**	**£**
TOTAL	**16,005,639**	**£424,266.89**
LYPFT	6,298,577	£310,975.02
NHSPS	1,874,639	£90,260.77
PFI	7,428,263	£0.00
PRIVATE	404,180	£23,031.10

Table 1.2J

% Change from previous year (Total electricity and gas 2017/18)		
Ownership	**kWh**	**£**
TOTAL	**-1068,211**	**-6.26%**
LYPFT	-270,772	-4.12%
NHSPS	55,194	3.03%
PFI	-829,339	-10.04%
PRIVATE	-23,295	-5.45%

Table 1.2K

Total electricity 2017/18		
Ownership	**kWh**	**£**
TOTAL	**5,095,442**	**£277,542.29**
LYPFT	1,727,295	£192,438.46
NHSPS	611,763	£70,082.21
PFI	2,630,977	£0.00
PRIVATE	125,387	£15,021.63

Table 1.2L

% Change from previous year (Total electricity 2017/18)		
Ownership	**kWh**	**£**
TOTAL	**-67,972**	**-1.32%**
LYPFT	-45,371	-2.56%
NHSPS	23,681	4.03%
PFI	-45,292	-1.62%
PRIVATE	-989	-0.78%

Graph 1

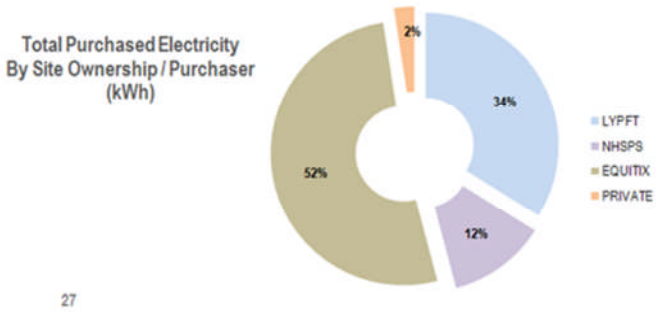


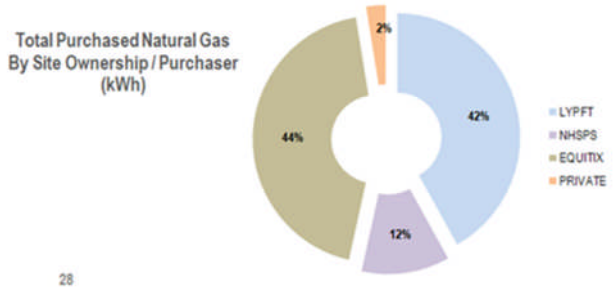
Table 1.2M

Total natural gas 2017/18		
Ownership	**kWh**	**£**
TOTAL	**10,910,197**	**£146,724.59**
LYPFT	4,571,262	£118,536.56
NHSPS	1,262,876	£20,178.56
PFI	4,797,266	£0.00
PRIVATE	278,793	£8,009.47

Table 1.2N

% Change from previous year (Total gas 2017/18)		
Ownership	**kWh**	**£**
TOTAL	**-1,000,240**	**-8.40%**
LYPFT	-225,401	-4.70%
NHSPS	31,513	2.56%
PFI	-784,047	-14.05%
PRIVATE	-22,305	-7.41%

Graph 2

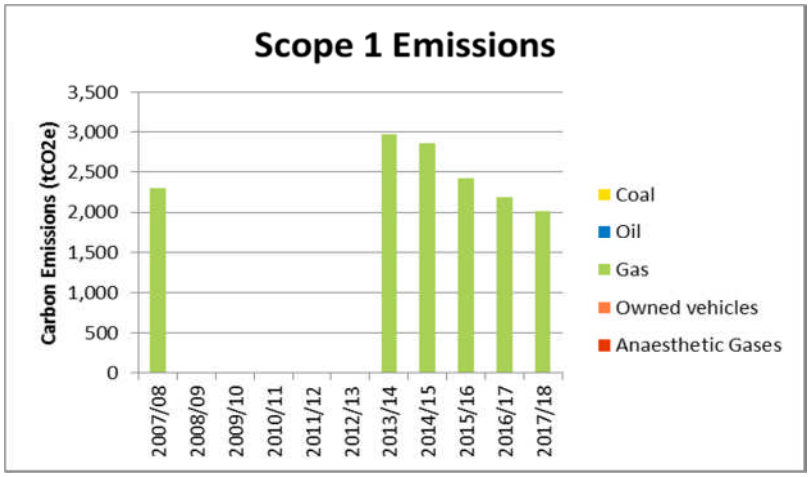


1.2.3.2.7 Our modelled carbon footprint

Table 1.2IO - Reported carbon emissions

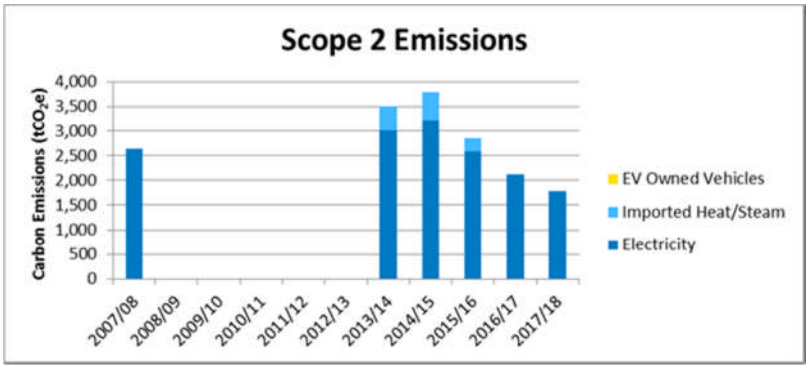
	2007/08	2013/14	2014/15	2015/16	2016/17	2017/18
Total carbon emissions (tCO2e)	**6106**	**8192**	**8237**	**6641**	**5506**	**4948**
Scope 1: Gas emissions (tCO2e)	2304	2973	2855	2423	2191	2009
Scope 2: Electricity esissions (tCO2e)	2645	3011	3233	2591	2128	1791
Scope 2: Heat/steam emissions (tCO2e)	0	495	558	256	0	0
Scope 3: Business mileage – grey fleet (tCO2e)	332	710	557	525	362	277
Scope 3: Commute (tCO2e)	824	1002	1034	846	825	870
Percentage reduction on previous year	**10.13%**					
Percentage reduction on 2013/14 base year	**39.60%**					
Percentage reduction on 2007/08	**18.96%**					

Graph 3



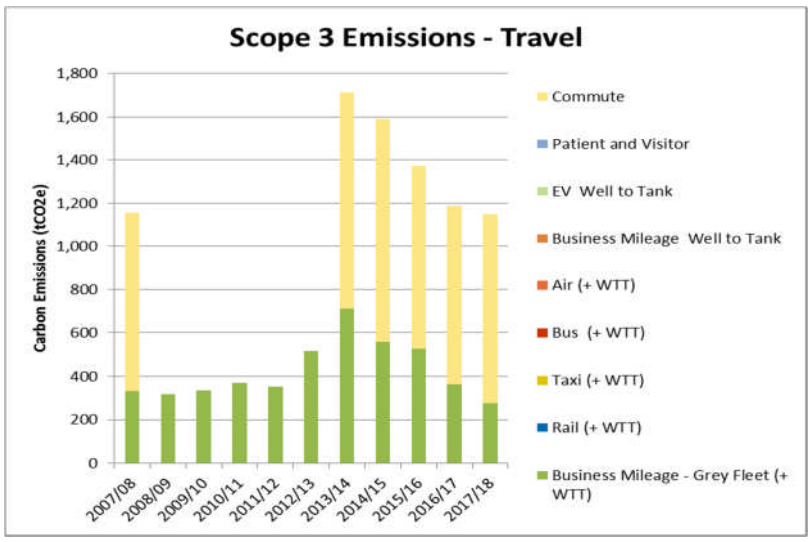
Scope 1 Emissions include direct Greenhouse gas emissions associated with the combustion of natural gas, coal and oil in both owned and leased buildings, emissions associated with fuel combustion in owned fleet vehicles and fugitive emissions associated with the use of anaesthetic gases

Graph 4



Scope 2 Emissions include indirect emissions associated with the generation of purchased electricity consumed

Graph 5



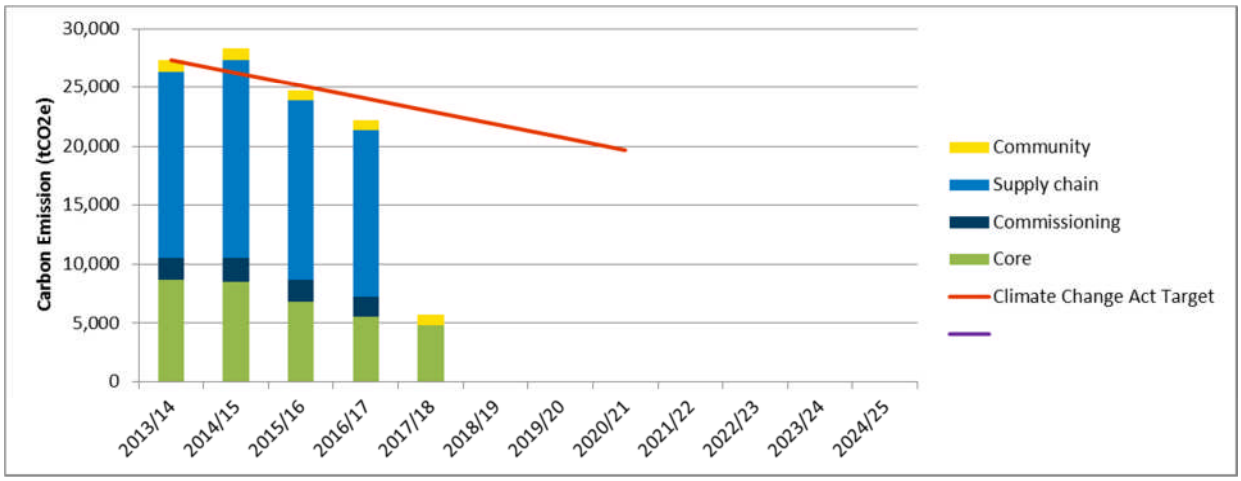
Scope 3 Emissions for this year include only Travel related emissions from staff commute and business mileage

1.2.3.2.8 Modelled trajectory

Our Modelled carbon footprint and trajectory

According to the modelled trajectory we are on track to further reduce emissions in line with wider NHS reduction targets.

Graph 6



1.2.3.2.9 Our 12-month key objectives for 2018/19

Featured Improvements

Extended cycle to work scheme

Our Cycle to Work Scheme provided in partnership with Evans Cycles and Vivup has been extended to be available year round to help promote more sustainable modes of travel for staff commuting to work. This has seen an increase in take up which we hope to expand on further next year.

Waste optimisation project

Working with our new waste contractors SWR we have improved the monitoring and measurement of mixed recycling and general waste and are working through an optimisation plan which will see the following improvements:

- New signage across all Trust sites to promote better segregation
- Site based recycling targets to support our SDMP target of increased recycling volumes
- Food waste reduction project to reduce water use and sewage burdens associated with food maceration
- Adoption of glass recycling across all trust sites
- Project investigating the viability of hand dryers in place of paper towels for non-clinical Trust locations

Promoting re-use

To promote re-use of equipment and furniture across trust locations and to donate unwanted items to other trusts and local public bodies reducing unnecessary disposal we have signed up to warp-it re-use/re-distribution service and look forward to reporting the carbon and cost savings attributed to this service in the coming year.

1.2.3.3 Anti-bribery culture

We have a zero tolerance to bribery and the Board has in place an Anti-Bribery and Fraud Policy which is available to staff on Staffnet. Staff are reminded of their responsibilities under the procedure and how to access this on a regular basis. Counter-fraud services are provided by NHS Audit Yorkshire who carry out proactive and where necessary will carry out reactive work in relation to bribery. They will make a report to each meeting of the Audit Committee to provide on progress with their work. In 2017/18 there have been no instances of bribery identified within the Trust.

CONFIRMATION FROM THE CHIEF EXECUTIVE

As Chief Executive I confirm that the information in this Performance Report (made up of sections 1.1 and 1.2 of this Annual Report) is accurate to the best of my knowledge and that I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Signed  Date: 24 May 2018

Dr Sara Munro
Chief Executive

SECTION 2.1 – THE ACCOUNTABILITY REPORT (Directors' Report)

The directors are responsible for keeping proper accounting records, which disclose with reasonable accuracy at any time the financial position of the Trust and enable them to ensure that the accounts comply with the requirements outlined in the above-mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors consider that to the best of their knowledge and belief they consider the Annual Report and Accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy.

2.1.1 Members of the Board of Directors

At the end of 2017/18 the Board of Directors was made up of seven non-executive directors (including the Chair of the Trust) and six executive directors (including the Chief Executive). The table below lists members of the Board of Directors on 31 March 2018. It shows the name of the Chair of the Trust and Deputy Chair; the Senior Independent Director; the Chief Executive and the Deputy Chief Executive.

Table 2.1A – Members of the Board of Directors on 31 March 2018

NON-EXECUTIVE TEAM		
Prof Sue Proctor	Chair of the Trust	3-year appointment from 1 April 2017
Prof John Baker	Non-executive Director	3-year appointment from 1 September 2016
Helen Grantham	Non-executive Director	3-year appointment from 15 November 2017
Margaret Sentamu	Non-executive Director	3-year appointment from 31 July 2017
Sue White	Non-executive Director (Deputy Chair of the Trust)	3-year appointment from 7 November 2016
Martin Wright	Non-executive Director	3-year appointment from 20 January 2018
Steven Wrigley-Howe	Non-executive Director (Senior Independent Director)	3-year appointment from 17 February 2016
EXECUTIVE TEAM		
Dr Sara Munro	Chief Executive	
Joanna Forster Adams	Chief Operating Officer	
Dawn Hanwell	Chief Financial Officer (Deputy Chief Executive)	
Dr Claire Kenwood	Medical Director	
Susan Tyler	Director of Workforce Development	
Cathy Woffendin	Director of Nursing and Professions	

Non-executive directors (NEDs), including the Chair of the Trust, are appointed by the Council of Governors. Where there is a vacancy this would be filled through a full open advertisement process. Where there is an incumbent NED who is eligible for re-appointment by virtue of the number of years they have served and where they wish to be considered for re-appointment, this would be done based on a satisfactory appraisal and approval by the Council of Governors. Should it be necessary to remove either the Chair of the Trust or any of the other non-executive directors this will be done by the Council of Governors. A decision to remove the Chair of the Trust or another non-executive director must be done in accordance with our constitution and only if three quarters of the total number of governors appointed or elected at the time, vote to remove an individual.

The Board of Directors considers that it is balanced, complete and appropriate and this can be seen in the biographical details of Board members as set out in Part A section 3.3 of this Annual Report. All the non-executive directors are considered to be independent in both judgement and character, and the Board has confirmed there are no relationships or circumstances which are likely to affect, or could appear to affect, judgment in this respect.

It is also reported that Prof Sue Proctor as the Chair of the Trust had no other significant commitments during the year 2017/18 that affected her ability to carry out her duties to the full, and she has been able to allow sufficient time to undertake these duties.

Further information about the Board of Directors can be found in Part A sections 2.4 and 3 of this Annual Report.

2.1.2 REGISTER OF DIRECTORS' INTERESTS

Under the provisions of the constitution, we are required to have a register of interests to formally record any declarations of interests of members of the Board of Directors. The register will include details of all directorships and other relevant material interests, which both executive and non-executive directors have declared.

On appointment members of the Board of Directors must declare any interests, which might place, or be seen to place them in a potential conflict of interest between their personal or private interests and those arising from their membership of the Board of Directors. None of the interests declared, conflict with their role as a director.

Members of the Board of Directors are also required to declare any conflict or pecuniary interests that arise in the course of conducting Trust business, specifically at each meeting of the Board, and make an annual declaration of interest to ensure declarations remain up to date.

The register of interests is maintained by the Head of Corporate Governance and is available for inspection by members of the public on request. The Head of Corporate Governance can be contacted by telephone 0113 8555930 or by email chill29@nhs.net.

2.1.3 DIRECTORS' STATEMENT AS TO DISCLOSURE TO THE AUDITORS

For each individual who is a director at the time this Annual Report was approved, so far as the directors are aware, there is no relevant audit information of which the Trust's auditor is unaware; and the directors have taken all the steps that they ought to have taken as directors in order to make themselves aware of any relevant audit information and to establish that the auditor is aware of that information.

2.1.4 DISCLOSURE FOR THE PAYMENT OF CREDITORS

We adopt the Better Payment Practice Code, which requires payment of all our undisputed invoices by the due date or within 30 days of receipt of goods. Further information can be found in note 9 of the Annual Accounts in Part C of this Annual Report. There has also been no interest paid under the Late Payment of Commercial Debts (Interest) Act 1998.

2.1.5 INCOME DISCLOSURE

The Trust is required under Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) to ensure that income from the provision of goods and services for the purposes of the health service in England is greater than its income from the provision of goods and services for any other purposes. The Trust has met this requirement in 2017/18. The Board of Directors, therefore, declares that there has been no material income other than from the provision of goods and services for the purposes of the health service in England. Any benefit is re-invested in the provision of those services.

2.1.6 COST ALLOCATION AND CHARGING

The Trust has complied with the cost allocation and charging requirements set out in the HM Treasury and the Office of Public sector Information guidance.

2.1.7 POLITICAL AND CHARITABLE DONATIONS

The Board reports that it has not made any political or charitable donations and that it is not the policy of the Leeds and York Partnership NHS Foundation Trust to make any such payments.

2.1.8 NHS IMPROVEMENT'S WELL-LED FRAMEWORK

In January 2017 the Board asked Deloitte LLP to carry out an independent review of our governance arrangements against the NHS Improvement well-led framework. The Board decided to do this so it had assurance that the Trust met the standards of good practice.

The first phase of the review looked at sub-Board level structures and processes i.e. structures and processes at executive director (corporate) through to directorate (care service) level.

In May 2017 Phase 1 was concluded. Deloitte found a lot of good practice in the Trust, but they are made a number of recommendations. These were accepted by the Board and an action plan was drawn up which was implemented during 2017/18. Executive director leads were identified for each action and progress was monitored through the Senior Leadership Team meetings.

Phase 1 looked at the arrangements over three main headings which are detailed in the paragraphs below. The key findings and actions were as follows:

Table 2.1B

Corporate and divisional leadership capacity and capability	• Executive directors' portfolios were better aligned which led to some functions moving between executive directors. • Strengthening the leadership arrangements for operational and professional leadership in the care groups.
Corporate governance; structures roles and accountabilities	• Reviewing and strengthening meeting arrangements by looking at when meetings take place in the month / year to allow reporting through to Board in a timely way thereby ensuring there are clear lines of reporting and escalation at all levels • Standardising the way in which meetings are held by introducing standard meeting templates to be used for all formal meetings in the Trust, producing a Meetings Administration Manual, and providing training for staff on all aspects of running meetings • Establishing eight executive-led governance groups to oversee the operational reporting and day-to-day monitoring of the work of the Trust covering areas of clinical practice, risk, workforce, finance, service performance and developments • Establishing an internal programme of peer reviews and visits within our services • Implementing consistent governance structures across the care groups.
Accountability and performance management arrangements	• Developing the Governance Accountability Assurance and Performance Framework which sets out clearly the arrangements for managing performance within corporate functions and care services • Publishing of an annual business cycle with key milestones for the development of service and care group plans.

Phase 2 of the review was completed in September 2017. It looked at Board and committee effectiveness. This focused on:

Table 2.1C

Strategic development and oversight	• Complete the development of the supporting strategies and delivery plans, ensuring they include clear delivery milestones and success measures
Organisational culture	• The Workforce and Organisational Development Strategy currently in development will need to clearly set out plans and milestones for a programme of cultural transformation • Board service visits will need to be well communicated to staff • Consideration given to the nursing/allied health professional leadership structures in place.
Committee effectiveness	• Review the roles and frequency on the Board sub-committees to ensure they are able to effectively carry out their duties. • Establish a Strategy Investment / Development Committee to undertake more detailed scrutiny of significant commercial opportunities or strategic capital and investment plans • Introduce a chair's report to the parent group to report issues for assurance and concerns
Performance information	• Introduce a Board level performance report which is integrated and aligned to strategic objectives and is encompassing of best practice in relation to analysis, presentation and benchmarking • Recruit substantively to the Head of Performance role

Executive oversight of the recommendations and actions from this phase has been provided by the Executive Management Team and assurance provided on progress to the Board through regular reports.

This review against the Well-led Framework strengthened our existing internal governance arrangements and our systems of internal control. It made clear to staff where decisions are taken and where risks or issues are escalated to; where accountability sits and what assurance looks like. It provided us with a comprehensive system of monitoring, evaluating and reporting on performance. The changes also ensure that we are clear about the performance measures we need to report against and where these are reported to. We have reviewed and refreshed the Board Assurance Framework and strengthened our quality governance reporting, including drawing up a Quality Plan which sets out our approach to service improvement

The key arrangements that are in place to ensure we are well-led are:

- An experienced leadership team with the skills, abilities, and commitment to provide high-quality services. We recognise the training needs of managers at all levels, including those of the leadership team, and provide development opportunities for the future of the organisation
- The Board and Senior Leadership Team has set a clear vision and values that are at the heart of all the work within the organisation and we ensure staff at all levels understood them in relation to their daily roles
- The newly developed trust strategy is directly linked to the vision and values of the trust and we have involved stakeholders in the development of the strategy. We also have five strategic plans which have been aligned to each other and to the delivery the strategy.
- Senior leaders visit all parts of the trust and feed back to the board to inform the discuss in relation to the challenges staff and the services face
- We are actively engaged in collaborative work with external partners including NHS partners, primary care, Local Authorities, the voluntary sector, and the local transformation plans
- The Board has sight of the most significant risks and mitigating actions through the Board Assurance Framework

- Appropriate governance arrangements are in place in relation to Mental Health Act administration and compliance
- We have a structured and systematic approach to staff engagement
- The Board reviews performance reports that included data about the services. We also have an Executive Performance Overview Group which allows executive directors and service managers and staff to be sighted on their key performance indicators (KPIs) and any issues to delivery
- We are committed to improving services by learning from when things go well and when they go wrong; we also promote research and innovation.

In January 2018 we received an inspection from the CQC. The report was issued and said staff were "caring and compassionate during their interactions with patients" and that "feedback from patients confirmed that staff treated them well and with kindness, compassion and respect." It also said that "patients were positive about the care and treatment they received and felt involved in the decision-making" and that "staff involved carers and others close to patients in decisions about the care and treatment provided by the service."

The report showed that 85% of the Trust's services are now rated as either good or outstanding. However; there were still a number of issues to resolve including three services rated as 'Requires Improvement' alongside some actions the Trust needs to take centrally. As such the Trust has been rated 'Requires Improvement' overall.

The Trust was given the following overall ratings by the CQC:

Table 2.1D

Are services safe?	Are services effective?	Are services caring?	Are services responsive?	Are services well-led	Overall
Requires improvement	Requires improvement	Good	Good	Good	**Requires improvement**

Whilst the CQC raised a number of risk areas, there were no incidences or evidence of service users receiving poor treatment or inappropriate care. There are however a number of areas we still need to address which has meant our overall rating has stayed at requires improvement. This was disappointing as services have worked very hard and made so many improvements, many of which have been recognised in the CQC's report.

We are looking at the actions we need to take to address the findings and will put these in place as quickly as possible in time for our next inspection.

SECTION 2.2 – ACCOUNTABILITY REPORT (Service User Care)

2.2.1 SERVICE USER CARE

We put the health, safety and wellbeing of our service users and carers at the heart of everything we do. This is borne out in our Trust Strategy and our five strategic plans. Our principal activity is to provide excellent quality mental health and learning disability care that supports people to achieve the very best they can for their health and learning disability care the supports people to achieve the very best they can for their health and wellbeing. We work together with our partners to offer service users a choice of interventions and to ensure that our services provide a joined-up pathway of care. This section shows what we have done in respect to the services we provide.

2.2.1.1 Principal activities of our care groups

The Care Services directorate includes those services that provide direct clinical care to our service users in Leeds and across Yorkshire and the Humber.

The directorate is made up of two care groups, these are:

- Leeds Mental Health Care Group
- Specialist Services and Learning Disabilities Care Group.

This arrangement of services: strengthens clinical leadership and ensures that the care we provide for service users is safe and effective; matches the delivery of our care to the local commissioning groups and specialist commissioners who ask us to provide care and services; and makes sure that our services are grouped together to deliver pathways and packages of care to our service users which reduce delays and are joined up to give people the right care at the right time from the right service.

Leeds Mental Health Care Group

The Leeds Mental Health Care Group provides a range of acute and community-based services to service users over the age of 18. The services we provide in the care group are commissioned by Leeds Clinical Commissioning Group and include:

- Community Mental Health Teams
- Care Home Team
- Memory Service
- Crisis Assessment Services
- Intensive Community Services including the Home-Based Treatment Team
- Younger People with Dementia Team
- Psychological and Psychotherapy Services
- Assertive Outreach Team
- Older People's Liaison Mental Health Service (based at St James's Hospital)
- Mental Health Inpatient Services
- Dementia Inpatient Service
- Rehabilitation and Recovery Services
- Healthy Living Service.

Specialist Services and Learning Disability Care Group

The Specialist Services and Learning Disability Care Group is made up of a range of specialist services operating on a local, regional and national basis. These services are:

- Forensic Services
- CAMHS Tier 4 Inpatient Services
- Learning Disability Services
- Eating Disorders Services
- Gender Identity Services

- Liaison Psychiatry
- National Deaf Children and Families Service
- Northern School of Child and Adolescent Psychotherapy (NSCAP) Clinical Services
- Perinatal Services
- Personality Disorder Services.

Our services are delivered across a range of settings in Yorkshire and the Humber and our Deaf CAMHS service operates from Manchester and Newcastle. They are commissioned by a range of commissioners, including national specialised commissioning (NHS England), local CCGs, the Local Authority and Public Health. A number of our services are also delivered through formal partnerships with other agencies.

Key achievements of the care groups during 2017/18

- **Implemented and embedded health coaching**: working with our city-wide partners we have successfully established a model for health coaching for use as a clinical intervention and to support self-management
- **Implemented a new learning disability community services model**: we have successfully implemented a new service model for the way we provide our learning disability community services.
- **Started work on redesigning our community services**: this is a long-term project to develop our community mental health service pathway to provide a new community and crisis model for older and working age adults. This work will continue into 2018/19
- **Successfully bid for the veterans mental health service contract**: a new service which focuses on providing core mental health support to veterans
- **Identified as the lead provider for the eating disorders new care model:** much work was undertaken during the year including service user engagement, recruitment of new staff and the redesign of clinical pathways. Agreement was given that this will go live on 1 April 2018

Future priorities for the care groups in 2018/19

The key priorities for the care groups are stated within the Clinical Services Strategic Plan which is a three-year plan for 2018 to 2020. A number of priorities have been identified as being key to the first year of the Plan, 2018/19, and these include:

- Continuing the implementation of a new community and crisis model for older and working age adults
- Integrating the specialist liaison outpatient model with Leeds Teaching Hospitals NHS Trust and identify growth opportunities in non-acute outpatient care
- increasing our specialist triage provision to ensure we are able to respond to people who visit the emergency department in crisis within 1 hour
- Implement an enhanced Care Homes Service that will offer intensive assessment and support to newly place care home residents
- Implement a new forensic community outreach model that provides specialist community support and intervention for service users with on-going significant / complex mental health needs
- Implementation of the new veterans service
- Redesign our low secure model at Clifton House in York
- Continue to work to reduce the number of people placed out of area in line with our trajectory to meet the April 2021 target of zero
- Implementation of the new care model for adult eating disorders.

The priorities will be delivered by staff in the care groups, with Project Management Office support and regular reports on progress to our Board, its sub-committees and to our operational groups.

Risks and challenges for the care groups in 2018/19

We continue to operate in a complex national picture; with uncertainties around commissioning intentions, recruitment and retention challenges, and financial pressures.

We need to balance the delivery of high quality care with our cost improvement plans and overall our regulatory control total. Those working in our services strive to look at ways in which care can be delivered differently without compromising quality or the service users' experience. We have an ambitious plan for 2018/19 and the things we want to do, but we are only able to deliver our priorities if we have the capacity in our services. We, like all other NHS organisations, face risks around filling our vacancies and ensuring we have the right clinical staff to provide the care our service users expect from us; and the right management structure in place to oversee the delivery of the priorities. To help support us in this the Board have has agreed a Workforce and Organisational Development Plan which sets out how we will achieve the workforce we need to deliver these priorities.

We also need to ensure that the premises from which we provide our services are fit for purpose and provide the right therapeutic environment. This means that we will need to make some changes to where services are provided and we will work with our staff and service users to ensure we get this right and involve people in the changes.

Our IT systems also need to support the delivery of high quality care. In 2018/19 we will be procuring and implementing a new electronic patient records system. Changing such a large IT system presents a number of risks to our day to day business. These will be managed through the project team overseeing this and staff in the care groups will be involved in the implementation and changes.

We also need to work with our commissioners and partners in the health and care sectors within which we provide services to ensure that we are able to meet the needs of our service users not just when they are in our services, but when they are cared for by our partners. This means that we will need to continue to develop our partner relationships and look at ways of working differently to provide the care needed.

2.2.2 SERVICE USER EXPERIENCE

2.2.2.1 Feedback from people who use our services (our service user survey)

We gather feedback from people who use our services and their carers through a broad range of methods including both local and national surveys. Every NHS service provider must run a national service user survey each year for both inpatient and community services. The surveys are managed by an independent company (Quality Health) which sends a questionnaire to a sample of representative community service users and inpatients, then works with the answers given to produce result 'scorecards' that can be compared with other mental health trusts and community interest companies which deliver mental health services. This helps us to benchmark our performance in regard to service user experience on at least an annual basis.

The National Community Mental Health Survey 2017 placed us in the top 20% of all 52 Trusts, and many of these scores have also improved since 2016. The response rate was 26% (213 useable responses from a useable sample of 819) which is disappointingly lower than last year's response rate and services are being asked to support an improvement in the uptake this year.

However, we were placed in the top 20% of trusts for treating people with dignity and respect; a rating that improved from last year's community survey result in addition to us being placed in the top 20% of trusts for service users receiving support in finding and keeping work.

The National Acute Inpatient Mental Health Survey 2017 placed all but one of our scores in either the top 20% or middle 60%, when compared to the 18 other organisations surveyed with most of the scores showing improvement since the 2016 survey. The response rate at 17% (45 useable responses from a useable sample of 260) was an improvement compared to last year's figures but as the returns are low, it's important that we work to ensure this feedback is triangulated with feedback from other sources.

However, inpatient services showed that we achieved three of the best overall national scores within Care and Treatment in relation to explaining the purpose of medication completely; explaining medication side effects completely and giving enough privacy when discussing condition or treatment.

In addition to this overall, 84% of our service users rated the care given during their inpatient stay as excellent, very good or good.

Our 2017 results on service user feedback are encouraging. In almost every area of our work we've maintained our service levels or improved slightly.

That doesn't mean we're at all complacent. The comments our service users have made give us plenty to think about and work on and we have made pledges about what we will do to provide even better services. In addition to the pledges, we are also reviewing the system used to capture our friends and family test feedback as we are experiencing low numbers due to the way the system is currently commissioned.

In the community survey, a key issue of concern was a fall in the experience of treatments and therapies being explained to service users and service users' experience of being involved as much as they wanted to be in deciding what treatment or therapy to use.

For inpatient services just one of our scores was in the bottom 20% of Trusts, and related to service users feeling unfairly treated during their most recent stay.

Amongst a number of improvement actions, we have pledged to:

- Make sure that our service users develop their care plan with their mental health and social care professionals and are given a hard copy with an agreed date to review it
- Investigate reasons for service users feeling unfairly treated while in hospital
- Take further action to make service users feel safer while in hospital.

2.2.2.2 Dealing with concerns – our complaints and PALS service

Complaints are seen by the Trust as a valuable source of feedback which can be used to inform service improvements, enabling us to provide high quality services for our patients and carers. They present an opportunity to review both patient care and our services whilst examining the way we interact and provide information to our service users.

Complaints management training has been in place since May 2015 and over 150 members of staff have been trained in the handling of complaints since this time. Feedback from the training highlighted a need for additional customer service training for front-line support staff. As a result, a 'customer services' training package was developed. A total of 14 sessions were held in 2017/18 aimed at front-line support staff as they represent the face of the Trust and are the ones whom visitors / callers speak to first and the people staff go to first for information. Good front-line staff will create an environment where courtesy, helpfulness and a warm welcome are standard.

The Trust recognises the importance of learning from complaints and the value of sharing this learning across the organisation. Once a complaint has been investigated, the complainant is informed within the response letter, where action will be taken to ensure the events leading to their experience, are put right. Often this may involve individual staff members reflecting on the way they have provided care, team discussions for wider group learning, staff training or use of the complaint as a case study.

Overdue complaints are continually monitored by the Complaints and Claims Manager with any areas of concern being raised with the Head of Nursing and Patient experience. The Complaints team regularly prompt investigators and Associate Directors for progress updates on all complaints; but there are still occasions when capacity issues delay the final approval stage. We are working on ways to reduce any delays and have a clear escalation process when required.

Learning from complaints is disseminated through the CLIP (Complaints / Compliments, Litigation, Incidents and PALS) report via Clinical Governance Councils. Learning is also shared through Lessons Learnt bulletins, or through Ward Managers and Community Managers Forums and the Consultants Committee, when appropriate.

Staff often receive compliments verbally or by letter and card. They are thanked for treatment, care and support, or complimented on the environment of the ward. As a result, there is now a formal process in place for recording compliments as a key measure of service user experience. During 2017/18 there were 343 compliments formally recorded.

The PALS team received 1778 enquires during 2017/18. The PALS team is supported by one social work student from Leeds Beckett University who commenced a 90-day placement as part of their MA in social work. This has created more capacity for promoting the service and increasing activity. As a result, the PALS team has been hosting 'PALS surgeries' within our inpatient units (Becklin Centre; Newsam Centre; The Mount; Clifton House; and Mill Lodge). These have been very positively received.

2.2.3 HOW WE ARE USING OUR FOUNDATION TRUST STATUS TO IMPROVE CARE

We were authorised as a foundation trust in August 2007. Since this time we have made good use of the benefits of our foundation trust status.

Our ambition is simple. We want to support our service users, carers, our staff, and the communities we serve to live healthy and fulfilling lives. We use various initiatives to help us to achieve this ambition. One of which is that we remain committed to working in partnership with the people who use our services, their families and friends and our external partners, to develop and improve our services. This enables us to achieve our ambition whilst ensuring engagement with service users and carers remains at the centre of our work.

In addition to the people we have traditionally worked with, being a foundation trust brings the added benefit of being able to recruit a membership; people who are passionate about mental health and learning disability services. From this membership we are then able to form a Council of Governors; people, elected and appointed, who have an important role in helping us to develop the way in which we deliver services.

During 2017/18 we have used the benefits of being a foundation trust in the following ways:

- Members and governors continued to help develop the shape and direction of our services in Leeds, York and North Yorkshire, especially around future scoping and planning of priorities through the strategic planning process.

- At the Annual Members' Meeting in September 2017 attendees were invited to join a conversation about how the Trust could improve the way it listens and acts on feedback from services users, carers, families and members. The feedback was captured and a summary of how it has been integrated within the Trust will be presented at the 2018 Annual Members' Meeting.

- Part of the Annual Members' Meeting was made up of our public meeting where members of the Board of Directors and Council of Governors made reports to members and the public on the work and performance over the previous financial year.

- Members and governors made a significant contribution to re-imagining our strategy through methods such as crowdsourcing.

- Governors attended a West Yorkshire Mental Health Services Collaborative Engagement Event, which was run in partnership with three other NHS Trusts, two of which are foundation trusts. These organisations provide the region's NHS mental health services. Governors provided feedback direct to this project which was captured and forms part of the forward plans about how we would work together on future service developments.

- Governors were invited to be attendees of a Strategy Project Group, overseeing the redevelopment of the Trust's Strategic Plan; Workforce and Organisational Development Group, an operational group that supports the achievement of the Trust's Workforce and Organisational Development Plan; and NHS 70 Project Group, looking at initiatives to recognise and celebrate within the Trust.

- Two non-executive directors (Helen Grantham, and Martin Wright) were appointed by our Council of Governors, each for a three-year period. The governors also appointed the Deputy Chair of the Trust (Sue White) for a two-year period.

- Governors continued to form part of the service visits that the non-executive directors undertake. These visits provide an opportunity for all involved to find out more about the services that the

Trust provides. It also provides the governors with a chance to see the role that non-executive directors undertake in staff engagement by them providing an independent view on the Trust's services and holding the executive directors to account.

- We continued to invite governors to observe a number of Board sub-committees, this included the: Quality Committee, Mental Health Legislation Committee, and Finance and Performance Committee. This provides an opportunity for governors to get a better understanding of the work of the Trust and to observe non-executive directors appropriately challenging the executive directors for the operational performance of the Trust.

- Governors were encouraged to provide feedback on the work of the Council of Governors. This included having one-to-one meetings with the Chair of the Trust and resulted in themes being identified such as areas of interest. A number of actions were agreed. These being to help develop and support the Council of Governors collectively and governors individually.

- Governors appointed KPMG as the new external auditors for the Trust with effect from 1 October 2017.

- Two rounds of elections were held for vacant seats on the Council of Governors. Members had the opportunity to become further engaged with the work of the Trust by standing to become a governor within the elections, and be part of any ballot that takes place. The composition of the Council of Governors continues to remain a priority for the Trust to ensure that the Trust is representative of the members and people that the Trust provides services to.

- Governors were invited to provide feedback on the performance of the seven non-executive directors, including the Chair of the Trust. This anonymous feedback contributed to a 360 degree feedback approach used as part of the appraisal process for each of the non-executive directors.

2.2.4 REGULATORY RATINGS AND PERFORMANCE

Information about our performance against key healthcare targets, our performance against national standards and targets, and actions resulting from Care Quality Commission inspections can be found in Part A section 2.7 and the Quality Report in Part B of this Annual Report.

For locally agreed targets these are reported in the Combined Quality and Performance Report (CQPR) and are shared with the commissioners, the Board of Directors and the Executive Team. We also have quarterly Quality and Performance meetings with the commissioners and progress against targets and measures is discussed and where necessary remedial action plans are agreed.

2.2.5 RESULTS OF THE 2017/18 NHS EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE ASSURANCE PROCESS

The Trust is required to carry out an annual assessment of its compliance with NHS England's core standards for Emergency Preparedness, Resilience and Response (EPRR). This assessment is considered by our EPRR group and is then approved by the Board of Directors. For 2017 we assessed ourselves as 'substantially compliant'. Four areas of partial compliance were identified and plans have been developed to address these areas.

SECTION 2.3 – ACCOUNTABILITY REPORT (Stakeholders)

2.3.1 PARTNER AND STAKEHOLDER RELATIONS

2.3.1.1 Mental Health Collaborative

This Trust, along with Bradford District Care Foundation Trust, South West Yorkshire Partnership Foundation Trust and Leeds Community Healthcare, came together to form the West Yorkshire Mental Health Services Collaborative. This brings together collective expertise from the region's providers of mental health services.

The focus of the collaborative will be to work together to improve acute and specialist mental health services for our local communities and deliver the Mental Health Five Year Forward View for people in West Yorkshire. A number of priorities have been agreed and work streams established to ensure delivery of the priorities. Executive directors and senior managers from within the Trust are part of these work streams which feed into the key priorities and day-to-day operation of the Trust.

At the March meetings of the respective Boards the governance arrangements were agreed including the agreement of a Memorandum of Understanding and the establishment of a Committees in Common. Representation from the Trust on this committee will be the Chair and Chief Executive. These arrangements will ensure there are mechanisms in place to review progress and the delivery of our shared agenda.

2.3.1.2 West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP)

The Trust continues to participate as a key partner in the West Yorkshire and Harrogate Health and Care Partnership, formally the STP. The focus of the partnership is to set out the vision, ambitions and priorities for the future of health and care in the West Yorkshire region. We have been an active participant in the development of the partnership with our executive team members taking an active role in the development of plans and governance arrangements.

For the WY&H HCP it has been agreed to develop a Memorandum of Understanding that seeks to set out the governance and accountability arrangements. The development of the governance arrangements is expected to continue into 2018/19. Representation on the WY&H HCP comes from our executive team and senior leaders in the organisation as the focus of the work feeds into our key priorities and day-to-day operation of the Trust.

2.3.1.3 Humber Coast and Vale Health and Care Partnership (HC&V HCP)

The primary focus for the Trust in this HCP is the development of our forensic services in line with the national review of forensic provision being led by specialist commissioners. In particular we have been asked to lead on the development of a new service model for low secure forensic services for the footprint. The business model for this is to reinvest resources that have previously been fixed within inpatient units into alternative models of provision.

2.3.1.4 Partnerships at service level

Alongside developing our new strategy, we have been continuing to deliver and develop our services. Our plans for community mental health services have been influenced by the Leeds Mental Health Framework 2014 to 2017. The Framework was developed from a partnership review of all mental health services across Leeds, led by the Leeds Clinical Commissioning Groups (CCGs) and in collaboration with Leeds City Council, NHS primary care, adult social care, third sector organisations and ourselves.

At a service level there we have well established links with our partners. As part of our community and crisis redesign proposed model we have worked alongside Forum Central in order to jointly plan and host a third sector partnership engagement event on our proposal. In addition we have an extensive database of partners who we are from across Leeds that we will be engaging with in order to share are proposed model.

2.3.2 PUBLIC AND SERVICE USER INVOLVEMENT

2.3.2.1 Consultations

There have been no formal public consultations in 2017/18.

2.3.2.2 Public involvement activities

Through the Trust's Communications Team we have both an internal and external focus for involving our service users, carers, staff and the public. During 2017/18 we have ensured the services we provide and the partnerships we make have been supported in the following ways:

- **A new improved website -** We launched a new website in March 2017 which has had a positive impact on how we communicate with all stakeholders, particularly service users, carers and the public
- **The big conversation at Annual Members' Day 2017** – Our Annual General Meeting and Annual Members' Day took place on 19 September 2017. The day featured a 'big conversation' with service users, carers, members, staff and third sector partners about how we can improve how we listen and act on feedback
- **Membership and Stakeholder Communications –** We have reviewed and re-launched the Trust's *Imagine* Magazine in 2017/18 following a research and discovery exercise. The magazine now has an entirely new look which reflects the Trust's new brand and visual identity, which in turn has been developed from the Trust's new strategy, vision and values
- **Supporting involvement within the LGBT+ community via our Rainbow Alliance –** The team has supported the creation and promotion of the Trust's new Rainbow Alliance network during 2017/18. The Alliance is a network of staff, service users and carers committed to enhancing the quality of services the Trust delivers to the LGBT+ community. The Alliance's brand as well as its terms of reference, key messages have been promoted through ongoing events and training opportunities via internal and external communications
- **Support for Love Arts Festival 2017 –**The yearly Love Arts Festival took place in October 2017. This was held over 15 days with an aim to start conversations about mental health and challenge stigma while helping people in recovery from mental ill health connect with the vibrant culture in Leeds
- **Engaging stakeholders in Trust Board business –** We have invested in digital communications to promote the business of the Board and engage more people with it. This has included digital communications such as advance promotion of meetings and invitations to attend and submit questions, live tweeting from board meetings using the hashtag #LYPFTBoard. There is also a blog from the Chair, Prof Sue Proctor, giving her highlights of the meeting following each board meeting
- **Engaging people through social media** – We also promote widely what we do through the Trust's social media channels, including Twitter, Facebook, LinkedIn and You Tube.

2.3.2.3 Service user involvement activities

The ''you said, we did'' community meetings remains a key activity to keep service users and carers up to date with local events and plans for our wards and services. The meetings are an opportunity for the people who use our services to give feedback and share ideas, alongside receiving timely responses about any issues of concerns.

We have a well-established service user network (SUN) This is a monthly meeting where service users and carers get together to share their experiences of Trust services, as well as providing a platform to support the shaping and influencing of service provision and development. Guest speakers are invited at the request of members where issues have been identified or raised within the network. Members also have the opportunity to become involved in research projects, delivering training and recruitment.

April 2017 to March 2018 saw 282 people attend throughout the year and work is currently in progress to increase membership further with a particular focus on hard to reach and diverse communities. SUNRAYS has also been set up in locality areas to provide a similar platform to help extend our ability to reach a wider group of stakeholders and the team are keen that working in partnership with other statutory, third-sector and voluntary organisations will help us to achieve our end goals. Our York based services will also be supported to feel more included and share their experiences.

A key area for the Patient Experience and Involvement Team is to ensure that we have a fit for purpose engagement model. An external review will be undertaken which will influence and provide key improvement plans for future experience and involvement across the trust ensuring that collating and learning from feedback at the right time and in the right place becomes less of a challenge.

The Patient Experience Team will continue to be responsive during the review and is currently in the process of designing a campaign to recruit volunteers who can help and support involvement, surveys, events family and friend's feedback and other work streams.

SECTION 2.4 – ACCOUNTABILITY REPORT (Remuneration Report)

2.4.1 INTRODUCTION

In company law, senior managers are defined as 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the foundation trust'. For the purpose of this Remuneration Report, the description 'senior managers' refers to the executive and non-executive directors holding positions on the Board of Directors.

This Remuneration Report contains details of senior managers' remuneration and pensions. It also sets out further information about the appointment of those senior managers (where these have occurred during 2017/18) as required by NHS Improvement's Code of Governance. The narrative and figures in this report relate to those individuals who have held office as a senior manager during 2017/18.

The information in sections 2.4.2 to 2.4.5 below is not subject to audit by our external auditors, KPMG; however, they will read the narrative to ensure it is consistent with their knowledge of our Trust.

2.4.2 ANNUAL STATEMENT ON REMUNERATION

The information provided in Sections 2.4.2 to 2.4.4 forms the annual report from the chair of the committees that are responsible for the remuneration of the executive and non-executive directors.

Remuneration for senior managers is determined by two committees: the Remuneration Committee (a sub-committee of the Board of Directors made up of all the non-executive directors), which is responsible for the remuneration relating to the executive directors; and the Appointments and Remuneration Committee (a sub-committee of the Council of Governors made up of a majority of governors), which is responsible for the remuneration relating to the non-executive directors.

2.4.2.1 Remuneration Committee – executive directors' remuneration

With regard to executive directors, the overarching policy of the Remuneration Committee is to: use benchmarked figures to ensure they are in line with other similar organisations; ensure equity within the executive team pay structure, taking account of levels of experience; and reference the Department of Health guidance on Very Senior Managers (VSM) salaries. A further consideration when determining the overall level of remuneration is the differential between the amount paid to an executive director and their direct reports to ensure the overall level of responsibility for executive directors is recognised. When awarding percentage pay uplifts ('cost of living awards') the committee is always mindful of the percentage awarded to staff, which is used as a benchmark. There is no performance-related pay in any director's current contract of employment. Where a salary requires review, a benchmarking exercise may be requested to make comparison against other similar NHS organisations and similar posts.

Further information about the work of the Remuneration Committee during 2017/18 can be found in section 2.4.4.2 below.

2.4.2.2 Appointments and Remuneration Committee – non-executive directors' remuneration

The overarching policy for the remuneration of the non-executive directors (NEDs) is to award levels in line with other comparable NHS foundation trusts, using benchmarked figures. When awarding annual percentage uplifts ('cost of living' awards) to non-executive directors the committee will be mindful of the amount awarded to staff on Agenda for Change pay bandings.

Further information about the work of the Appointments and Remuneration Committee during 2017/18 can be found in section 2.4.4.3 below.

2.4.3 SENIOR MANAGERS' REMUNERATION POLICY

2.4.3.1 Future policy tables

This section describes the policy narrative relating to the components of the remuneration packages for executive and non-executive directors. Each of the components detailed in these tables supports the Trust's Strategic Objective 2: we provide a rewarding and supportive place to work (putting in place a benchmarked remuneration package to fairly remunerate our Board; recognising the liability and responsibility they carry; attracting an appropriately skilled and qualified senior team to lead the organisation).

Table 2.4A – Remuneration policy for executive directors

Element	Policy
Salary	The overarching policy of the Remuneration Committee is to: use benchmarked figures to ensure they are in line with other organisations; ensure equity within the executive team pay structure, taking account of levels of experience; and reference the Department of Health guidance on Very Senior Managers (VSM) salaries. A further consideration when determining the overall level of remuneration is the differential between the amount paid to an executive director and their direct reports. There are no annual increments associated with executive directors' salaries.
Taxable benefits	This will, in the main, be any mileage rates paid which are over and above the HMRC threshold or any other benefit in kind applicable at the time of remuneration.
Annual performance related bonuses	The Trust does not pay any annual performance-related bonuses to executive directors. (Section 2.4.3.2 below sets out the process for performance appraisals (not linked to pay)).
Long-term performance-related benefits	The Trust does not pay long-term performance related bonuses to executive directors. (Section 2.4.3.2 below sets out the process for performance appraisals (not linked to pay)).
Pension-related benefits	Pension rights for executive directors are determined by the NHS Pension Scheme. The maximum payable (by the employee and the employer) is determined by the NHS Pension Scheme.
Percentage uplift (cost of living increase)	The Remuneration Committee will decide if the executive directors are to be awarded a percentage uplift ('cost of living' increase) for each financial year and what level this will be. In doing this the committee is mindful of the uplift awarded to staff on Agenda for Change pay bandings.
Other remuneration (e.g. relocation expenses)	Any other expenses paid to executive directors would be paid in accordance with the relevant Trust policy. There are no items of other expenditure which are applicable only to executive directors.

Table 2.4B – Remuneration policy for non-executive directors

Element	Policy
Fee payable	The overarching policy for the remuneration of the non-executive directors (NEDs) is to award levels in line with other comparable NHS foundation trusts using benchmarked figures. The maximum amount that can be paid will be determined by the Appointments and Remuneration Committee and ratified by the Council of Governors. There are no annual increments associated with non-executive directors' remuneration.
Additional fees for any other duties	The remuneration for the Chair of the Trust recognises the specialist role and extra time commitment over and above that of the other NEDs. The Chair of the Audit Committee is also remunerated differently in recognition of the specific skills and responsibility this role requires. All other non-executive directors are remunerated equally; however, for those NEDs who chair a Board sub-committee (excluding the Audit Committee, which attracts a separate level of remuneration) there is an honorarium of £1,000 per annum (paid pro-rata). This honorarium is in recognition of the added workload and responsibility that comes with chairing a Board sub-committee

Element	Policy
	The maximum amount that can be paid will be determined by the Appointments and Remuneration Committee and ratified by the Council of Governors.
Percentage uplift (cost of living increase)	The Appointments and Remuneration Committee will decide if the non-executive directors will be awarded a percentage uplift ('cost of living' increase) and what level this will be. In doing this the committee is mindful of the uplift awarded to staff on Agenda for Change pay bandings.
Travel	Travel costs will be reimbursed through the payroll and will be supported by a completed travel claim form supported by appropriate receipts. Costs incurred will be reimbursed on a like-for-like basis with mileage being paid at a fixed pence per mile.
Pension contributions	No pension deductions are made from non-executive directors' remuneration and no contribution is made to a pension fund in respect of any non-executive director.
Other remuneration	Any other expenses paid to non-executive directors would be paid in accordance with the relevant Trust policy. There are no items of other expenditure which are applicable only to non-executive directors.

It should be noted that paragraph 7.2 of the executive directors' contract allows the Trust to recover any monies owed at any time via deductions from salary.

With the exception of the agreement to pay chairs of Board sub-committees an honorarium of £1,000 per annum (excluding the Audit Committee), there have been no new components of the remuneration packages for either executive or non-executive directors since the 2015/16 Remuneration Report. There have also been no changes to the policy relating to the existing components of the remuneration package since the last Remuneration Report.

It should be noted that employees of the Trust are paid on Agenda for Change (AfC) bandings with an incremental scale; executive and non-executive directors are paid on a fixed salary which has no element of incremental scale. The level of salary paid to those on AfC is determined nationally, whereas the remuneration of the executive and non-executive directors are determined by the Remuneration Committee and the Appointments and Remuneration Committee respectively, informed by appropriate policy and benchmarking data.

2.4.3.2 Performance and appraisals

2.4.3.2.1 Overview

Performance and appraisals are not linked to remuneration and there is no element of performance related pay in senior managers' salaries or remuneration packages.

The Board of Directors is committed to continuous improvement and it undertakes an evaluation of its performance as part of its meeting. We also have in place a 360-degree evaluation process for members of the Board with information from this being fed into the appraisals of individual members.

The appraisal of individual Board members identifies strengths and good performance, and also areas for development. The appraisal looks at an individual's development needs, which informs tailored development plans.

All executive and non-executive directors undertake compulsory training. Furthermore, regular Board of Directors workshop sessions take place with some being used specifically for Board development.

2.4.3.2.2 Executive Directors

Objectives are set for each executive director in conjunction with the Chief Executive (the Chief Executive's objectives are set in discussion with the Chair of the Trust). These objectives are monitored through the appraisal process. The Chair of the Trust carries out the appraisal of the Chief Executive against agreed objectives, and appraisals for the other executive directors are carried out by the Chief Executive against their agreed objectives. The Chair of the Trust will contribute to the appraisal of each

executive director in regard to their performance as a member of the unitary Board. This will be fed back to the Chief Executive for inclusion in their overall appraisal.

The Remuneration Committee will be assured that a process is in place and has been completed for each executive director including the Chief Executive.

2.4.3.2.3 Non-executive Directors

Objectives are set for each of the NEDs in conjunction with the Chair of the Trust (the Chair's objectives are set in discussion with the Senior Independent Director and Lead Governor). Performance against these is monitored through one-to-one meetings.

The NEDs have their objectives agreed with the Chair; the Chair agrees their objectives in conjunction with the Senior Independent Director and the Lead Governor. Appraisals of the non-executive directors are carried out by the Chair of the Trust with the Lead Governor in attendance. The Senior Independent Director conducts the appraisal of the Chair of the Trust. Governors and members of the Board are invited to provide feedback on each of the NEDs and the Chair which informs the appraisal discussion. The Council of Governors will receive assurance that the process is in place and has been completed effectively.

2.4.3.3 Policy on payment for loss of office

The executive directors' contract contains details of the grounds on which a directors' contract may be terminated. The contract also contains information about the circumstances under which PILON (payment in lieu of notice) may be paid.

Payment for loss of office or in lieu of notice does not apply to non-executive directors as they are appointed not employed.

2.4.3.4 Statement of consideration of employment conditions elsewhere in the Trust

In determining the level of salary for executive director posts conditions for employment elsewhere in the Trust will be taken into account in particular the salaries of direct reports to ensure there is sufficient differential to take account of the level of liability and responsibility that Board members have. In determining 'cost of living' increases, the Remuneration committee and the Appointments and Remuneration Committee will take account of the percentage increase awarded to staff on Agenda for Change pay bands. The Trust has not consulted with staff when setting its remuneration policy.

2.4.3.5 Policy on notice periods

All contracts for executive directors are permanent and therefore open-ended. The period of notice for each executive director is set out in their contract and is normally three months. Non-executive directors do not have a contract of employment, they have an appointment letter. Non-executive directors are not subject to employment law or regulations and as such do not have a formal period of notice.

2.4.4 ANNUAL REPORT ON REMUNERATION

This section includes a description of the work of the committees that are involved in the appointments of both the executive and non-executive directors and which determine their respective salaries and remuneration. These are:

- The Remuneration Committee (a sub-committee of the Board of Directors) which is made up of all the non-executive directors and is chaired by the Chair of the Trust
- The Appointments and Remuneration Committee (a sub-committee of the Council of Governors) which is made up of a majority of governors and is chaired by the Chair of the Trust
- The Nominations Committee (a sub-committee of the Board of Directors) which is made up of a mix of executive and non-executive directors (NEDs) and is chaired by the Chair of the Trust.

2.4.4.1 Directors' contracts

Details of the contract start date for the Chief Executive and other members of the Executive Team who have served during 2017/18 are set out in the table below. As at 31 March 2018 the Director of Workforce Development (Susan Tyler) advised the Board of her intention to retire on 31 May 2018. Interim arrangements have been put in place and a recruitment process for a substantive appointment is being undertaken

Table 2.4C – Executive directors who have served during 2017/18

Name	Title	Date appointment effective from	Date left the Board position
Dr Sara Munro	Chief Executive	5 September 2016	N/A
Anthony Deery	Director of Nursing, Performance and Quality	3 November 2014	24 September 2017
Joanna Forster Adams	Chief Operating Officer	3 July 2017	N/A
Dawn Hanwell	Chief Financial Officer (Deputy Chief Executive)	1 August 2012	N/A
Dr Claire Kenwood	Medical Director	1 March 2017	N/A
Paul Lumsdon	Interim Director of Nursing. Professions and Quality	25 September 2017	28 February 2018
Lynn Parkinson	Interim Chief Operating Officer	1 January 2016	2 July 2017
Susan Tyler	Director of Workforce Development	1 January 2012	N/A
Cathy Woffendin	Director of Nursing and Professions	1 March 2018	N/A

Details of the non-executive directors who have served during 2017/18 are shown in the table below along with details of their terms of appointment.

Table 2.4D – Non-executive directors that have served during 2017/18

Name	Date appointment effective from	Term	Date appointment ends or ended	Number of the term of office
Prof Sue Proctor (Chair of the Trust)	1 April 2017	3 years	1 April 2020	First
Prof John Baker	1 September 2016	3 years	31 August 2019	First
Helen Grantham	15 November 2017	3 years	14 November 2020	First
Margaret Sentamu	31 July 2017	3 years	30 July 2020	Second
Jacki Simpson	15 February 2017	3 years *	19 September 2017	First
Julie Tankard	1 March 2016	3 years *	19 January 2018	Second
Sue White	7 November 2016	3 years	6 November 2019	First
Martin Wright	20 January 2018	3 years	19 January 2021	First
Steven Wrigley-Howe	17 February 2016	3 years	16 February 2019	Second

* Jacki Simpson and Julie Tankard left the Trust before the end of their term of appointment due to other work commitments.

2.4.4.2 The Remuneration Committee (a sub-committee of the Board of Directors)

The Remuneration Committee is a sub-committee of the Board of Directors. It has been established in accordance with the NHS Act 2006 and operates in accordance with the principles in NHS Improvement's Code of Governance for Foundation Trusts. It is chaired by the Chair of the Trust and is made up of all the non-executive directors. A copy of the Terms of Reference for this committee is available on our website.

The committee has a key role in providing the Board with assurance that: executive directors are rewarded appropriately for their contribution; appropriate contractual arrangements are in place; that there is a process for assessing the performance of individual executive directors against their agreed objectives, and that plans are in place to address any areas of development.

The Remuneration Committee is independent of the executive arm of the Board of Directors. However, during 2017/18 the committee took advice from the following officers of the Trust: Dr Sara Munro, Chief Executive who provided information in regard to the remuneration for executive directors; Susan Tyler, the Director of Workforce Development in relation to employment matters; and Cath Hill, the Head of Corporate Governance, who provided secretariat support and advice on matters of governance. In taking this advice the committee was mindful of any potential conflicts of interest and has dealt with these appropriately as evidenced in the minutes.

The Remuneration Committee has a key role regarding the recruitment and retention of appropriately qualified and experienced executive directors by agreeing appropriate reward packages. It exercises scrutiny of the remuneration of executive directors in regard to both salary and other areas of reward and has a core responsibility to ensure compliance with all legal obligations and regulations in respect of the employment and remuneration of executive directors.

During 2017/18 the committee met on five occasions with membership being made up of the Chair of the Trust and six non-executive directors. Its main areas of business were discussions in regard to:

- Agreeing 'cost of living' uplift of 1% for the executive directors with effect from 1 April 2017 for the executive directors in line with that paid to staff on Agenda for Change pay bandings
- A summary of the appraisals for the executive directors
- Review of the salaries for the executive directors, in particular: parity of remuneration within the executive team, recognition of experience, recognition of any expansion in portfolios and level of responsibility; and comparability with external benchmarking data. As a result there was an increase in the salaries for the Chief Financial Officer and the Director of Workforce Development
- Agreeing the secondment arrangements for the Director of Nursing, Professions and Quality (who left the Trust on 24 September 2017)
- The interim arrangements and remuneration package for the Interim Director of Nursing Professions and Quality who was appointed until a substantive appointment was being made
- The remuneration for the substantive post of Director of Nursing and Professions.

The membership of the Remuneration Committee is all the NEDs plus the Chair of the Trust. The table below shows the Remuneration Committee meetings that each member attended. The shaded boxes relate to those meetings that individuals were not eligible to attend due to their appointment date.

Table 2.4E – The Remuneration Committee

Name	25 May 2017	27 July 2017	28 September 2017	25 January 2018	22 February 2018
Prof Sue Proctor (chair of the committee)	✓	✓	✓	✓	✓
Prof John Baker	✓	✓	✓	✓	✓
Helen Grantham				✓	✓
Margaret Sentamu	-	✓	✓	✓	✓
Jacki Simpson	✓	✓			
Julie Tankard	✓	✓	✓		
Sue White	✓	✓	✓	✓	✓
Martin Wright				✓	✓
Steven Wrigley-Howe	✓	✓	✓	-	✓

2.4.4.3 The Appointments and Remuneration Committee (a sub-committee of the Council of Governors)

The term non-executive director used in this section refers to all non-executives, including the Chair of the Trust.

The Appointments and Remuneration Committee is a sub-committee of the Council of Governors. It is established in accordance with the NHS Act 2006 and operates in accordance with the principles of NHS Improvement's Code of Governance for Foundation Trusts. It sets the remuneration and terms of service for the non-executive directors and it also plays a role in the appointment of non-executive directors particularly in respect of the interview panels which are made up of members of the Committee.

The Committee meets as required and is made up of governors chosen by ballot by members of the Council to represent them. It is chaired by the Chair of the Trust and is supported by the Director of Workforce Development and the Head of Corporate Governance. In November 2017 elections were held for the Committee and Peter Webster was successfully appointed. At the end of 2017/18 its membership was Steven Howarth, Niccola Swan, Julia Raven and Peter Webster; all of whom are elected governors.

Where the Committee is discussing the remuneration for the Chair of the Trust these agenda items will be chaired by the Lead Governor.

In 2017/18 there were two formal meetings and one 'virtual' meeting of the Appointments and Remuneration Committee. The table below shows the number of meetings attended by each member. The shaded boxes relate to those meetings that individuals were not entitled to attend due to the date they were elected to or left the committee.

Table 2.4F – The Appointments and Remuneration Committee

Name	27 June 2017	17 July 2017 (virtual)	30 August 2017
Prof Sue Proctor (chair of the committee)	✓	✓	-
Steve Howarth	✓	✓	✓**
Julia Raven	✓	✓	-
Niccola Swan	✓	✓	✓
Peter Webster			✓*
Claire Woodham	✓	✓	

* Peter Webster was co-opted onto the committee for the August meeting to ensure it was quorate. However, he was later elected (November 2017) as a substantive member of the committee by the Council of Governors.

** Steve Howarth presided at this meeting.

In 2017/18 the main areas of work for the committee were:

- Agreeing a 'cost of living' uplift of 1% for the non-executive directors with effect from 1 April 2017. This level of uplift was recommended to the Council of Governors for ratification
- Review and benchmark the remuneration for the non-executive directors to ensure there is parity of remuneration with comparable organisations and that the role that members of the NED team are required to carry out are recognised. This resulted in the committee recommending an increase in the remuneration for the Chair of the Trust
- Recommending to the Council of Governors that there is an honorarium of £1,000 per annum (pro-rata) paid to those NEDs who chair Board sub-committees (excluding the Chair of the Audit Committee) in recognition of the added responsibility and workload this duty brings

- Forming interview panels for non-executive director appointments and making a recommendation to the Council of Governors to appoint Helen Grantham and Martin Wright.

The process of appointment and re-appointment for non-executive directors

Where there is a vacancy for non-executive directors, the appointment is normally carried out through a competitive interview process. However; where there is an incumbent NED and they are eligible by virtue of the number of years they have served as a NED for the Trust; and where they wish to be considered for re-appointment, the Council of Governors can agree to re-appoint the individual subject to a satisfactory appraisal.

Competitive interview process

The first step in any appointment process is for the Nominations Committee (a sub-committee of the Board of Directors) to define the skills and experience required on the Board and to agree a role profile and person specification. The Appointments and Remuneration Committee (a sub-committee of the Council of Governors) receives the agreed role profile and person specification, against which appointments are made. It is also the responsibility of the committee to agree the process and timetable for any appointment process. The process and timetable will then be ratified by the Council of Governors.

Candidates are sought using external search companies and through the NHS Jobs website. A panel consisting of a majority of governors headed by the Chair of the Trust will draw up a shortlist of candidates from the applicants. An interview panel will be formed from the membership of the Appointments and Remuneration Committee with a majority of governors on it (where possible four governors), the Chair of the Trust and an independent assessor. The panel will then conduct the interviews and choose the preferred candidate based on merit. Once the panel has made its choice, a recommendation is made to the Council of Governors and it is for the Council to ratify the recommended appointment.

Re-appointment process

Where there is a re-appointment process carried out, the Chair will conduct a 360 degree appraisal taking views from members of the Board and Council on the NEDs performance. An appraisal will then be carried out by the Chair which will include the Lead Governor. A report will be made to the Council of Governors by the Chair who will advise if the appraisal has been satisfactory. The Council of Governors will then be asked to ratify their re-appointment. If the Council has evidence that this it is not appropriate to re-appoint the individual then a competitive interview process will be carried out and the individual's appointment as a NED will come to an end.

Appointment / re-appointment of non-executive directors in 2017/18

In 2017/18 there were three appointments / re-appointments made by the Council of Governors. These were in respect of:

- Margaret Sentamu; re-appointed for a period of three years with effect from 31 July 2017
- Helen Grantham; appointed for a period of three years with effect from 15 November 2017
- Martin Wright; appointed for a period of three years with effect from 20 January 2018. It was agreed that there would be a period of hand-over from Julie Tankard to Martin who is the chair of the Audit Committee. As part of that handover Martin observed the Audit Committee meeting in January 2018.

2.4.4.4 The Nominations Committee (a sub-committee of the Board of Directors)

The Nominations Committee is a sub-committee of the Board of Directors. It is established in accordance with the NHS Act 2006 and NHS Improvement's Code of Governance for Foundation Trusts.

Its role is to: regularly review the structure, size and composition of the Board of Directors and make recommendations for changes where appropriate; identify the skills, knowledge and experience required for

vacant director posts (for both executive and non-executive directors); and ensure there are arrangements in place for succession planning within the Board.

Where the vacant post is for a non-executive director, the Nominations Committee will provide the Council of Governors' Appointments and Remuneration Committee with details of the agreed skills and experience required. Where the vacant post is for an executive director a panel, constituted in accordance with the NHS Act 2006, made up of a majority of non-executive directors, will lead on the appointment process to appoint to the agreed skill-set by a process agreed by the Nominations Committee

The Nominations Committee meets as required. It is chaired by the Chair of the Trust and its membership is made up of the Chief Executive, the Director of Workforce Development and at least two non-executive directors. The choice of which NED will be at any given meeting will depend on them not having a conflict of interest in any matter under discussion at that meeting. The committee is supported by the Head of Corporate Governance who provides secretariat support and advice on governance matters.

During 2017/18 the committee met on two occasions, both these meetings were 'virtual' meetings carried out by email because of the need to expedite matters quickly. The table below shows the number of meetings each member took part in.

Table 2.4G – The Nominations Committee

Name	July 2017	October 2017
Prof Sue Proctor (chair of the committee)	✓	✓
Dr Sara Munro	✓	✓
Margaret Sentamu	-	✓
Susan Tyler	✓	✓
Sue White	✓	✓
Steven Wrigley-Howe	✓	✓

During the year its main areas of work were:

- Agreeing the role description for a vacant non-executive director position, which was determined to be strategic workforce leadership and human resources
- Agreeing the role description for the substantive post of Director of Nursing and Professions.

Appointment of executive directors in 2017/18

In 2017/18 three executive directors joined the Board

- Joanna Forster-Adams whose appointment process was carried out in 2016/17, but took up her post on 3 July 2017
- Paul Lumsdon; appointed as the Interim Director of Nursing, Professions and Quality (pending a substantive appointment) and was on the Board between 25 September 2017 and 28 February 2018
- Cathy Woffendin who took up the substantive post of Director of Nursing and Professions with effect from 1 March 2018.

Information in sections 2.4.5 to 2.4.7 is subject to audit by our external auditors, KPMG.

2.4.5 DIRECTORS AND GOVERNORS' EXPENSES

The following table sets out the total paid to directors (executive and non-executive) and governors for out-of-pocket expenses for travel and subsistence during 2017/18.

Table 2.4H – Directors and governors' expenses

	2017/18			2016/17
	Number in office throughout the reporting period	Number receiving expenses in the reporting period	The aggregate sum paid in the reporting period £'00	The aggregate sum paid in the reporting period £'00
Executive directors	9	4	7	5
Non-executive directors	9	7	11	14
Governors *[1]	23	6	13	21

*[1] Appointed governors have not been included in this figure as their organisations pay the cost of travel

Please note that expenses relating to executive and non-executive directors are shown in more detail the expenses payments column in table 2.4J below.

2.4.6 SENIOR EMPLOYEES PENSION ENTITLEMENTS, REMUNERATION AND BENEFITS IN KIND

Accounting policies for pensions and other retirement benefits are set out in the notes to the annual accounts; see Part C of this Annual Report.

The disclosure on senior employees' remuneration and pension entitlements is subject to audit by our external auditors, KPMG.

Information about pension entailments, remuneration and benefits in kind are set out in table 2.4I and 2.4J below.

Table 2.4I – Pension entitlement for senior employees (executive directors)

Name and title	Real increase in pension at age 60 (Bands of £2500) £'000	Real increase in pension lump sum at age 60 (Bands of £2500) £'000	Total accrued pension at age 60 as at 31 March 2018 (Bands of £5000) £'000	Lump sum at age 60 related to accrued pension at 31 March 2018 (Bands of £5000) £'000	Cash equivalent transfer value at 31 March 2017 £'000	Cash equivalent transfer value at 31 March 2018 £'000	Real increase in cash equivalent transfer value £'000	Employer's contribution to stakeholder pension To nearest £100
Dr Sara Munro (Chief Executive)	10.0 – 12.5	15.0 – 17.5	30 - 35	80 - 85	289	440	151	0
Dawn Hanwell (Chief Financial Officer and Deputy CEO)	5.0 – 7.5	15.0 – 17.5	45 - 50	145 - 150	844	1,008	164	0
Joanna Forster Adams (Chief Operating Officer)	30.0 – 32.5	75.0 – 77.5	40 - 45	100 - 105	0	694	517	0
Cathy Woffendin (Director of Nursing and Professions)	0.0 – 2.5	5.0 – 7.5	25 - 30	65 - 70	0	471	40	0
Dr Claire Kenwood (Medical Director)	47.5 – 50.0	147.5 – 150.0	45 - 50	145 - 150	0	985	985	0
Anthony Deery (Director of Nursing, Professions and Quality)	0.0 – 2.5	2.5 – 5.0	35 - 40	105 - 110	680	750	70	0
Susan Tyler (Director of Workforce Development)	2.5 – 5.0	7.5 – 10.0	50 - 55	155 - 160	1,055	1,174	119	0
Lynn Parkinson (Interim Chief Operating Officer)	0.0 – 2.5	2.5 – 5.0	40 - 45	130 - 135	748	823	76	0
Paul Lumsdon (Interim Director of Nursing and Quality)	0.0 – 0.0	0.0 – 0.0	0 - 0	0 - 0	0	0	0	0

Cash Equivalent Transfer Value (CETV) - The CETV is the actuarially assessed capitalised value of the pension scheme benefits accumulated by a member at a particular point in time. The benefits valued are the member's accumulated benefits and any contingent spouse's pension payable from the scheme. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Non-executive directors do not receive pensionable remuneration and consequently there are no entries for them in this report

- Lynn Parkinson was Interim Chief Operating Officer until 2 July 2017.
- Joanna Forster Adams was appointed Chief Operating Officer with effect from 3 July 2017
- Anthony Deery was Director of Nursing, Professions and Quality until 24 September 2017
- Paul Lumsdon was Interim Director of Nursing, Professions and Quality from 25 September 2017 until 28 February but remained in the Trust until 13 March 2018.
- Cathy Woffendin was appointed Director of Nursing and Professions from 1 March 2018
- Dr Claire Kenwood was appointed Medical Director with effect from 1st March 2017. Due to the timing of the appointment, pension's information was not available at the time of producing the 2016/17 Annual Report and so there is no prior year comparator.

Real increase figures have been allocated pro-rata for directors starting during the year. For the two employees that have left director roles (Anthony Deery and Lynn Parkinson), but who remain on the Trust's the full increase is shown.

Table 2.4J – Remuneration and benefits in kind for senior staff

Name and title	2017/18							2016/17						
	Salary (bands of £5000) £'000	Expenses payments (taxable) (rounded to nearest £100) £'	Performance pay and bonuses (bands of £5000) £'000	Long-term performance pay and bonuses (bands of £5000) £'000	All pension related benefits (bands of £2,500) £'000	Other remuneration (bands of £5,000) £'000	Total (bands of £5000) £'000	Salary (bands of £5000) £'000	Expenses payments (taxable) (rounded to nearest £100) £'	Performance pay and bonuses (bands of £5000) £'000	Long-term performance pay and bonuses (bands of £5000) £'000	All pension related benefits (bands of £2,500) £'000	Other remuneration (bands of £5,000) £'000	Total (bands of £5000) £'000
Dr Sara Munro (Chief Executive)	145-150	300	0	0	255.5 – 257.5	0	405 - 410	80 - 85	100	0	0	512.5 – 515.0	5 - 10	595 - 600
Dawn Hanwell (Chief Financial Officer and Deputy CEO)	125 - 130	100	0	0	130.0 – 132.5	0	255 - 260	110 - 115	0	0	0	80.0 – 82.5	0 - 5	195 – 200
Joanna Forster Adams (Chief Operating Officer)	80 - 85	0	0	0	912.5 – 915.0	0	995 - 1000	0	0	0	0	0	0	0
Cathy Woffendin (Director of Nursing and Professions)	5 - 10	0	0	0	595.0 – 597.5	0	600 - 605	0	0	0	0	0	0	0
Dr Claire Kenwood (Medical Director)	135 - 140	0	0	0	1145.0–1147.5	0	1280-1285	10 - 15	0	0	0	0	0	10 – 15
Anthony Deery (Director of Nursing, Professions and Quality)	50 - 55	200	0	0	35 – 37.5	0	85 - 90	100 - 105	100	0	0	35.0 – 37.5	0	135 – 140
Susan Tyler (Director of Workforce Development)	100 - 105	100	0	0	70.0 – 72.5	0	175 - 180	100 - 105	100	0	0	40.0 – 42.5	0	140 - 145
Paul Lumsdon (Interim Director of Nursing, Professions and Quality)	25 - 30	0	0	0	0	0	25 - 30	0	0	0	0	0	0	0
Lynn Parkinson (Interim Chief Operating Officer)	20 - 25	0	0	0	35.0 – 37.5	0	60 - 65	95 - 100	0	0	0	90.0 – 92.5	0	185 – 190
Prof Sue Proctor (Chair of the Trust)	45 - 50	100	0	0	0	0	45 - 50	0	0	0	0	0	0	0
Helen Grantham (Non-execute Director)	0 - 5	100	0	0	0	0	0 - 5	0	0	0	0	0	0	0
Martin Wright (Non-executive Director)	0 - 5	100	0	0	0	0	0 - 5	0	0	0	0	0	0	0
Julie Tankard (Non-executive Director)	10 - 15	0	0	0	0	0	10 - 15	10 - 15	0	0	0	0	0	10 – 15
Steven Wrigley-Howe (Non-executive Director)	10 - 15	400	0	0	0	0	10 - 15	10 - 15	700	0	0	0	0	10 – 15
Margaret Sentamu (Non-executive Director)	10 - 15	200	0	0	0	0	10 - 15	10 - 15	100	0	0	0	0	10 – 15
Jacki Simpson (Non-executive Director)	5 - 10	100	0	0	0	0	5 - 10	0 - 5	0	0	0	0	0	0 – 5
Prof John Baker (Non-executive Director)	10 - 15	100	0	0	0	0	10 - 15	10 - 15	0	0	0	0	0	5 – 10
Sue White (Non-executive Director)	10 - 15	0	0	0	0	0	10 - 15	0 - 5	0	0	0	0	0	0 – 5

- Lynn Parkinson was Interim Chief Operating Officer until 2 July 2017.
- Joanna Forster Adams was appointed Chief Operating Officer with effect from 3 July 2017
- Anthony Deery was Director of Nursing, Professions and Quality until 24 September 2017
- Paul Lumsdon was Interim Director of Nursing, Professions and Quality from 25 September 2017 until 28 February but remained in the Trust until 13 March 2018.
- Cathy Woffendin was appointed Director of Nursing and Professions from 1 March 2018
- Dr Claire Kenwood was appointed Medical Director with effect from 1st March 2017. Due to the timing of the appointment, pension's information was not available at the time of producing the 2016/17 Annual Report and so there is no prior year comparator.

There are no directors with additional duties

2.4.7 FAIR PAY MULTIPLE

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

Below is a table showing the median remuneration (the Hutton Disclosure) of all staff compared with the remuneration of the highest paid employee and the comparison ratio between the two.

Table 2.4K – Median remuneration

	2017/18	2016/17
Band of highest paid directors' total remuneration (£'000)	145 - 150	150 – 155
Median Salary (£)	28,746	27,825
Ratio	5.13	5.48

The banded remuneration of the highest-paid director in the Trust in the financial year was £148,512 (2016/17, £153,008). Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions. The ratio was 5.13 times (2016/17, 5.48 times) the median remuneration of the workforce, which was £28,746 (2016/17, £27,825). The ratio has decreased partly due to the highest paid director this year being paid less than the previous year's highest paid director and partly due to there being less lower paid staff (administrators and support workers) than last year.

In 2017/18, 7 substantive employees (2016/17, 6) received remuneration in excess of the highest-paid director. Remuneration for these employees ranged from £148,545 to £175,384 (2016/17, £156,396 to £177,474).

The median salary is calculated based on data that is generated from our payroll system. All staff that were employed by the Trust on 31 March 2018 are included in the calculation.

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

2.4.8 ACCOUNTING POLICIES

Accounting policies for pensions and other retirement benefits are set out in note 1.5 of the annual accounts in Part C of this Annual Report. Details of senior employees' remuneration can be found in this Remuneration Report (senior employees for the purpose of the Remuneration Report are our executive and non-executive Board members).

CONFIRMATION FROM THE CHIEF EXECUTIVE

As Chief Executive I confirm that the information in this Remuneration Report (made up of sections 2.4.1 to 2.4.8 of this Annual Report) is accurate to the best of my knowledge and that I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Signed  Date: 24 May 2018

Dr Sara Munro
Chief Executive

SECTION 2.5 – ACCOUNTABILITY REPORT (Staff Report)

2.5.1 EQUAL OPPORTUNITIES

We believe in fairness and equality and above all value diversity in all aspects of our work. This is demonstrated by our commitment to improving health and improving lives for our service users and staff.

Everyone who comes into contact with our organisation can expect to be treated with respect and dignity. We are committed to eliminating discrimination and to the fair treatment of everyone, taking into account all 'protected characteristics' under the Equality Act 2010. If unfair discrimination occurs it will be taken very seriously and it may result in formal action being taken against individual members of staff, including disciplinary action.

We undertake an annual assessment to review equality progress across the organisation using the NHS Equality Delivery System framework and identify priority areas for action through this process. Progress is monitored through our Equality and Inclusion Group and membership includes staff, and service users to ensure there are wide ranging contributions to the development and implementation of the strategic equalities agenda.

During the last year a variety of work was undertaken including the delivery of Diversity and Inclusion CPD (Continuing Professional Development) events to over 300 staff, aimed at supporting cultural competence and inclusive practice. There was participation from staff within a wide variety of roles and occupational areas and included members of our flexible workforce, our bank staff and volunteers.

We established our Rainbow Alliance Network to develop the inclusivity of our services and processes for people who are LGBT+ (lesbian, gay or bisexual) and our WREN (Workforce Race Equality Network) to strengthen access to development and support opportunities for staff from Black and Minority Ethnic communities.

We also aim to ensure that we employ and develop a workforce that is diverse, non-discriminatory and appropriate to deliver modern healthcare. Valuing the differences of each team member is fundamental. It enables staff to create respectful work environments so we are able to deliver high quality care and services whilst giving service users the opportunity to reach their full potential.

2.5.2 DISABILITY AND EMPLOYMENT

Our recruitment and selection procedures take full account of the requirements of the Equality Act 2010 and the associated public sector equality duties. This includes giving full and fair consideration to applicants with a disability or long-term health condition. We have committed to the Mindful Employer Charter and through our annual health and wellbeing action plan we implement activities to further develop our Trust as a healthy workplace in respect of mental health. We are also a Disability Confident employer. This demonstrates we are positive about people with disabilities and support them to successfully attain and retain employment within our Trust.

We have supportive employment practices in place not only for those that we employ who have a disability, but for those who may become disabled whilst working for us. These include a support package within the Employee Wellbeing and Management of Sickness Absence Procedure; a process for the management of work-related stress including a stress pathway tool-kit; an Employee Assistance programme (EAP) providing counselling and other support to staff; flexible working arrangements; and a bespoke Occupational Health Service. These procedures and services support the employment and retention of disabled employees and the implementation of reasonable adjustments to take account of individuals' needs.

Our attendance procedures also take account of individual needs related to disability and provides for disability leave as a reasonable adjustment, to support people to remain in work. We have made

reasonable adjustments to working environments through the purchase of specialised equipment and have made necessary alterations to premises in respect of access to buildings.

In addition to this, our diversity training package aims to raise awareness of a wide range of diversity issues, including disability in order to minimise discrimination in all aspects of employment. Diversity training is compulsory for all staff and is required to be undertaken every three years. This ensures that our workforce is aware of current legislative and organisational requirements and best practice. We have developed an annual programme of development sessions to provide our staff with the knowledge and expertise they require when working with our service users and staff from diverse communities.

2.5.3 VALUING OUR WORKFORCE

Our workforce is our most valuable asset and we recognise this by making a commitment to ensure they are well trained, well informed and are given every opportunity to contribute not only to the delivery of services but also to the development of these and other new services.

2.5.3.1 Volunteers

As a Trust we value the contributions that our volunteers make to the experience of people accessing our services. Our volunteers have a variety of skills and experiences, including volunteers with personal lived experience. This is invaluable to providing inclusive, recovery-focused activities for our service users.

Our Voluntary Services department continues to provide a high quality service across our sites; working in partnership with volunteers, staff, service users and external voluntary organisations. We have achieved the Leeds Volunteering kite mark recognition by Leeds City Council and Voluntary Action Leeds that the Trust manages a volunteering programme where volunteers receive a high quality, positive volunteering experience.

We actively support our volunteers to build on their skills and confidence and volunteering with our Trust continues to be a route into paid employment or full-time / part-time education. During the last year we developed new areas of volunteering whilst continuing to support existing schemes and their volunteers. This included the development of gardening activities within our younger people's mental health services through partnership work with York Cares.

We continue to maintain and raise the profile of the value of volunteers both within our Trust and the communities we serve. We are extremely grateful for all the good work undertaken by volunteers and the feedback they provide as well as the difference they make to the lives of our service users, carers and staff.

2.5.3.2 Staffside – working with the trade unions that represent our staff

Staffside is the elected body of the representative trade unions in our Trust. Staffside meets at least monthly to discuss and question, on behalf of the wider union membership, any issues raised by the individual trade unions or by the Trust. This committee enables the trade unions to negotiate with one voice. The JNCC (Joint Negotiation and Consultation Committee) is the place where all issues raised at Staffside meetings are brought to the attention of management.

Staffside has many years of experience of successful partnership working with the Trust. We have achieved this through the nationally recognised *In Partnerships* agreement.

During the past year Staffside has contributed to the strategic agenda by continuing to have involvement in service redesign and management restructuring, and also in communication and engagement with staff. Staffside has:

- Actively encouraged staff to complete the annual staff survey which has resulted in an increased response rate
- Continued involvement in the development of our strategy and in workforce issues through regular dialogue with the Director of Workforce Development and senior operational managers
- Successfully worked in partnership with the Workforce Development Directorate and its managers to support staff going through significant change
- Contributed to the job evaluation process under Agenda for Change to ensure fairness and equity in pay banding
- Continued to support staff who are redeployed in order to minimise any redundancies
- Contributed to feedback and action planning for teams to improve employee relations and learn lessons
- Contributed to the review and development of employment procedures.

Staffside also provides information and advice to staff through the development of an internal intranet page on Staffnet. They can also be contacted by emailing staffside.lypft@nhs.net.

The following tables show the Trade Union facility time which is required to be reported under the Trade Union (Facility Time Publication Requirements) Regulations 2017.

Table 2.5A – Relevant union officials – The total number of employees who were relevant union officials during 2017/18

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
9	1.68

Table 2.5B – Percentage of time spent on facility time – The number of employees who were relevant union officials employed during 2017/18 and the percentage time of their working hours spent on facility time

Percentage of time	Number of employees
0%	0
1-50%	1
51%-99%	6
100%	2

Table 2.5C – Percentage of pay bill spent on facility time during 2017/18

Total cost of facility time	**£36,760**
Total pay bill	**£107,740k**
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	**0.034%**

Table 2.5D – Paid trade union activities during 2017/18

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	21.48%

2.5.4 STAFF ENGAGEMENT

Staff engagement continues to be a key component of the Trust's organisational development approach and to support successful implementation of our strategic objectives.

Annually and throughout the year we conduct the National NHS Staff Survey and also Staff Friends and Family Tests which provide us with valuable feedback from staff on a variety of key areas across the Trust.

In 2017/18 we continued to develop the *Your Voice Counts* programme to engage with staff via a number of initiatives which have included:

- Directors' service visits which give staff at all levels direct access to our directors
- The continuation of listening events, such as conversations with the Chief Executive where the Learning and Organisational Development Team accompanied our Chief Executive to hold a number of events with staff across the Trust to gain their views and input into the development of a new behaviours toolkit. The behaviours toolkit is a continuation of the work we started in 2016/17 following the co-creation of the Trust's values with staff, service users and stakeholders
- A number of workshops to provide staff the opportunity for commenting on and inputting into the Workforce and Organisation Development Strategy
- Following the 2016 Staff Survey results which indicated that levels of bullying and harassment experienced by staff were of a concern, we held a focus group and conducted interviews with staff on how we could improve their experiences. This resulted in the *Your Voice Counts* online Crowdsourcing conversation with took place during autumn 2017. A significant number of our staff made over 2000 contributions to the conversation, and these findings have been used to develop an overarching action plan which is now being taken forward for implementation.

Staff recognition is a key component of our engagement work. As part of this we hold an annual Trust Awards ceremony where we celebrate excellence, innovation, personal achievement and team working. In November 2017 we held a highly successful Trust Awards ceremony which saw a record breaking 126 nominations from across the Trust and also extended the award categories to 10 which included, team of the year (both clinical and non-clinical team of the year, employee of the year (both clinical and non-clinical), bank employee of the year, volunteer of the year, partnership award, health and wellbeing award, developing people award and leader of the year. In addition we also hold a monthly STAR awards scheme for staff, which recognises exceptional contributions from teams and individuals to our objectives and values throughout the year.

In November 2016 we launched our new staff intranet *Staffnet* which includes a new easier to navigate menu structure, working search facility and staff directory. Since its launch we have worked to refine and develop the new intranet, working with local users to improve the quality and accessibility of the content and develop the system to be effective and sustainable.

The Learning and Organisational Development team supported a number of senior management appointments in 2017/18, including the Director of Nursing and Professions and Chief Pharmacist. The appointment processes involved a range of staff and also service user representatives.

2.5.5 OUR STAFF SURVEY

2.5.5.1 Results from the NHS staff survey 2017

Each autumn we participate in the Annual NHS Staff Survey. Table 2.5E below shows our performance in respect of response rate, and tables 2.5F and 2.5G show the top and bottom five ranking scores as presented in the findings.

Table 2.5E – Staff survey response rate

2017 survey		2016 survey		
Trust	National average	Trust	National average	Trust movement between years
56.3%	52%	53%	50%	+3.3%

We continued to adopt a full census approach to the survey in 2017. We transitioned more staff to completing the survey via the online method (approx. 55% in 2017, up from 24% in 2016). Paper surveys continued to be provided to those teams where accessing the online survey would present a barrier to them participating.

We also maintained the approach taken in previous years to increase participation, which included a collation of dedicated staff, managers and Staffside representatives, who came together to steer delivery of the survey and encourage participation by staff at a local level. This year's response rate increased to 56.3% and is 4% above the national average for all mental health and learning disability trusts in England.

The 2017 results show significant improvements in two local key areas compared to the 2016 scores, including a reduction in the percentage of staff who have experienced physical violence from patients, relatives or the public in the last 12 months and staff feeling more supported by their immediate managers.

We are performing better than the national average for mental health and learning disability trusts in England across five key areas, four of which are related to improvements in staff health and wellbeing and an improved indication of a positive reporting culture where more staff feel able to raise errors and incidents when they occur.

The 2017 Staff Survey results show that our Trust's ranking had improved to position 13 out of the 25 learning and mental learning disability trusts in England. This was an improvement from position 16 in 2016.

Following the results of the survey in 2016 we commenced specific programmes of work to address some of the key themes and areas for improvement, and the 2017 results show that staff are reporting improvements in these areas. Some of the ways in which we have addressed staff concerns are set out below.

- We increased the opportunity for staff to engage with senior leaders across the Trust and have input into strategy. We introduced initiatives such as directors' service visits which give staff at all levels direct access to the Board. The continuation of listening events, such as conversations with the Chief Executive, also provide staff with opportunities to discuss concerns and raise issues directly with the Chief Executive and provide Board insight via a temperature check. Additionally, we held workshops with staff to engage with them on the development of the Workforce and Organisational Development Strategy.
- We also continued to focus on staff health and wellbeing and following on from the introduction of the new Employee Assistance Programme in 2017 we held a series of health and wellbeing roadshows across the Trust, as well as the introduction of a physical health check service and self-referral to our fast-track appointments for work related stress checks

and support. Again, these types of initiatives have helped increase our staff survey scores in these areas.

The tables below show the results from the 2017 staff survey; specifically the top five ranking scores. These show where we compare most favourably with other mental health and learning disability trusts in England.

Table 2.5F –Top five ranking scores

	Trust Score 2016	Trust Score 2017	National Average* 2017	Positive difference against national average*
Percentage of staff attending work in the last three months despite feeling unwell because they felt pressured to do so	49%	49%	53%	-4%
Percentage of staff feeling unwell due to work related stress in the last 12 months	35%	38%	42%	-4%
Percentage of staff working extra hours	70%	69%	72%	-3%
Percentage of staff reporting most recent experience of harassment, bullying or abuse (higher scores indicate a positive reporting culture – higher score is better)	64%	64%	61%	+3%
Percentage of staff reporting errors, near misses or incidents (higher scores indicate a positive reporting culture – higher score is better)	93%	95%	93%	+2%

*national average for all mental health and learning disability trusts in England.

Table 2.5G – Bottom five ranking scores

	Trust Score 2016	Trust Score 2017	National Average* 2017	Negative difference against national average*
Effective team working (the higher score out of 5, the better)	3.71	3.77	3.84	-0.7
Percentage of staff reporting most recent experience of physical violence (higher scores indicate a positive reporting culture – higher score is better)	94%	90%	93%	-3.0%
Effective use of patient/service user feedback (the higher score out of 5, the better)	3.57	3.59	3.72	-0.13
Staff motivation at work (the higher score out of 5, the better)	3.82	3.82	3.91	-0.09
Fairness and effectiveness of procedures for reporting errors, near misses and incidents (the higher score out of 5, the better)	3.62	3.67	3.75	-0.08%

*national average for all mental health and learning disability trusts in England.

2.5.5.2 Addressing areas of concern

An analysis of our Staff Survey results provides us with a basis for determining the main areas to focus on when developing our key areas for action in 2018. The Trust will continue to use the *Your Voice Counts* Crowdsourcing platform, as well as face-to-face listening events to engage with staff on strategic issues from the national staff survey key findings.

We have invested heavily in enhanced local team reporting for the 2017 Staff Survey results and are working with staff right across the Trust to deliver these results at a local level. Service area leaders will then work with their teams to identify three areas of improvement and local action plans will be developed to take this improvement work forward in 2018.

2.5.6 DEVELOPING PEOPLE

Learning and development is something we take seriously as we recognise that without a fully competent workforce we will be unable to deliver safe and effective care. We are committed to developing our workforce so they can make a difference to the community we serve. Recent staff survey results indicate that our staff recognise the investment we make in learning and development opportunities.

Leadership and Management Development

We are partnering with the NHS Leadership Academy to deliver accredited programmes to develop our current and aspiring leaders and managers. We are one of only a few NHS trusts to work with the Leadership Academy to deliver a Mary Seacole local programme, which blends the national approaches to leadership development with local priorities. Throughout 2017/18 we have developed five cohorts of leaders and managers, representing a wide cross section of the Trust workforce. In January 2018, work began to form a collaborative delivery model for the Mary Seacole Local programme. The collaborative is between our Trust and local mental health and Learning disability providers and the joint programme will start in April 2018.

In 2017/18 the Trust Leadership Forum was reviewed and re-launched to provide a significant development offer for our senior leadership community. The Trust's objective is to develop collective leadership based on leadership behaviours that reflect our Trust values. The forum workshops are facilitated by leading experts who can offer insight and challenge on various aspects of collective leadership as well as the input from our own internal leaders.

Trust Induction

During 2017/18 and following feedback from our new starters, the induction day has been developed into a Trust 'welcome event'. The new programme, launched in April 2018, allows us to formally welcome new starters and through engaging and interactive approaches focus on the Trust's values and behaviours and our services.

Team Development

Team effectiveness and development is a key priority in the Trust's Workforce and Organisational Development Strategic plan. Throughout 2017, we have worked in partnership with a number of teams from across the Trust to support them to improve their performance. In September 2017, the Trust committed to working with the Aston OD Team Journey. The approach is evidence based and developed from research conducted in the NHS by Professor Michael West. The six month programme is currently being used with a number of teams and there are plans to deliver this at scale across the organisation over the next three years.

Coaching and One to One Development

We have continued to use our coaching network to support staff in their development and to also develop a coaching culture within our organisation. We have delivered personal development workshops for staff to help them deal with change and to develop their personal resilience.

Apprenticeships and Vocational Training

We continue to offer development opportunities for our support staff, utilising funding from Health Education England and are working to ensure we maximise benefit from the Apprenticeship Levy. We are utilising apprenticeships to recruit into health care support worker roles and develop career development pathways for existing staff through the introduction of associate practitioner and nurse associate band 4 roles.

Technology Enhanced Learning

We continue to maximise the role of technology enhanced learning across our organisation to increase the flexibility in how staff access learning and development. This has included developing and resourcing e-learning, mobile learning, video and other online learning solutions for our staff and also NHS staff across the northern region. A real focus this year was to extend the use of our iLearn learning management system to support a wider range of learning and development interventions across the Trust.

2.5.7 HOW WE INVOLVE OUR STAFF IN UNDERSTANDING PERFORMANCE

Our performance information is shared with our Council of Governors and performance dashboards have been created at team, service and care group level, in order that we can share performance information with our staff.

2.5.7.1 Financial Performance

Financial plans are set in the context of an annual planning process. We are required to complete a two-year Operational Plan, refreshed annually and produced in the context of our overarching strategy. Key assumptions to be used are discussed by the Executive Team and the Board of Directors to ensure there is an understanding of the key assumptions being made and the impact on our use of resources rating.

Finance managers are integrated within the Care Groups, forming part of the leadership teams at this level. This ensures consistency and understanding across the Trust on service and financial objectives. In the context of the annual planning cycle, the agreement of the budgets for each year are discussed and agreed with the relevant lines of management in the organisation. Individual budget holders have an opportunity to discuss pressures (as well as efficiencies), which are considered for funding as part of the budgetary process.

The Board of Directors and the Council of Governors receive regular information regarding financial performance within the Combined Quality and Performance Report. The performance report highlights financial performance against plan; any significant variances; how these have occurred; and what action is required, if any. The Council of Governors receives a report on performance (including financial performance) which allows the Council to hold the non-executive directors to account for the performance of the Board (including financial performance) and to understand how they have challenged the executive directors in respect of any areas of poor performance or risks to performance.

At each meeting of the Joint National Consultative Committee (JNCC), Staffside representatives are informed of the current and forecast financial position, together with future prospects.

2.5.7.2 Contractual and regulatory performance

There has been a great deal of work this year to further develop existing and create new dashboards for service managers to access. These dashboards provide the Key Performance Indicator (KPI) data that services need in order to better manage the performance of their services. Work is also underway to link all our KPI data to the Care Quality Commission's (CQC) domains of safe, effective, caring, responsive and well-led.

We have reinstated a series of Quality Reviews, whereby staff visit services and assess them using the Key Lines of Enquiry template used by the CQC. The emphasis is on highlighting good practice and high quality care as well as recognising areas for improvement. As part of the reviews, progress against the CQC action plan for that specific area is also reviewed.

The main aim of this approach is to engage all staff in the quality agenda and build up a body of knowledge through the organisation on what good quality looks like. The visiting team will be

clinicians from other teams supported by staff from corporate services such as safeguarding, mental health act legislation and medicines management.

As set out in our Quality Strategic Plan we will continue to engage with our staff by introducing a Quality Exchange Forum which will highlight good practice to be shared with teams and colleagues across the Trust.

2.5.8 MENTAL HEALTH ACT MANAGERS

Mental Health Act Managers (MHAMs) are members of the public, appointed by the Board of Directors, together with a number of non-executive directors who act in this role. Their key responsibilities are to:

- Review the detention of service users who are either detained under the Mental Health Act or who have been placed on Community Treatment Orders (CTO)
- Discharge those service users who no longer meet the criteria to be detained or are subject to a Community Treatment Order.

The Board of Directors has established a Mental Health Legislation Committee as a sub-committee of the Board. During 2017/18 this committee was chaired by a non-executive director. It provides a mechanism for assurance on the robustness of arrangements in place for the Trust to meet its duties in respect of the Mental Health Act 1983. Providing information to the committee is the Mental Health Act Managers' Forum. This seeks to provide a forum for communication between the Mental Health Act Managers and Officers of the Trust. The forum is also chaired by a non-executive director to ensure a direct link to the Board of Directors in accordance with the Mental Health Act Code of Practice and has as its deputy chair one of the MHAMs.

The recruitment of further MHAMs continued during 2017/18 and twelve new MHAMs were appointed. Regular recruitment ensures diversity is addressed within the group and that the organisation retains sufficient panel members to review detentions and CTOs, in accordance with the Trust's own standard. Seven MHAMs will reach the end of their fixed term appointment on 31 March 2018 which reinforces the need to constantly refresh our group of MHAMs.

We are committed to ensuring that our MHAMs are appropriately trained for their role and that all new managers attend a one-day induction, followed by a period of observation with support from experienced MHAMs. On-going training is provided at forum meetings and during 2017 the MHAMs Forum identified a need to focus on training for MHAMs who chair review panels and this was facilitated in February 2018, the training was positively received.

A review of the MHAMs role was completed during 2017 and a new procedural document introduced to provide clarity. This prompted a remuneration review during 2017 where rates were reviewed by the Board but remain unchanged, this review will be completed annually, The Training Needs Analysis (TNA) for managers was also reviewed and the required mandatory training reduced to better reflect the responsibilities of the role,

In 2017/18 there were 60 appeal hearings, of which 57 were heard within our standard of 10 days. The MHAMs reviewed 248 renewals / extensions of detention and CTOs. A total of 17 nearest relative barring orders were heard. The Mental Health Legislation Committee monitors hearing data at its quarterly meetings and seeks assurance as to how processes can be made more effective.

We are appreciative of the time and commitment that Mental Health Act Managers and non-executive directors acting as Mental Health Act Managers have given this year. Once again we wish to thank everyone for their dedication and the skill they apply when undertaking this vital role.

We currently have 35 acting Mental Health Act Managers and the table below shows those people who have acted in this capacity during 2017/18.

Table 2.5H – Mental Health Act Managers during 2017/18

Mental Health Act Managers during the period 1 April 2017 to 31 March 2018				
Berni Addyman	Michael Hartlebury	Nasar Ahmed	Jenny Taylor	Kevin McAleese
Enid Atkinson*	Janis Bottomley	Marilyn Bryan	David Walkden*	Ismail Patel
Deborah Byatt	Rebecca Casson	Aqila Choudhry	Michael Yates	Claire Penten/Turvil
Brian Councell*	Andrea Kirbride	Judith Devine	Niccola Swan	James Morgan
Jill Hetherton*	Ian Hughes	Lorna James	Tom White	Muhammed Patel
Peter Jones	Brian Kemp*	Nicolle Levine	Alex Sangster	Shamaila Quereshi
Heather Limbach*	Andrew Marran	Graham Martin	Debra Pearlman	Claire Morris
John Devine	Viv Uttley	David Mayes	Anne Rice*	Keith Woodhouse
Jeffrey Tee	Trevor Jones			

* Retired from the role during 2017/18

Non-executive directors also acting as Mental Health Act Managers during 2017/18	
Sue White	Margaret Sentamu

2.5.9 SICKNESS ABSENCE

At the end of March 2018 our absence rate decreased to 4.79% from a position of 4.96% as at 31 March 2017 as a result of our focused work with teams and services and the implementation of our health and wellbeing initiatives.

The latest figures available from the Health and Social Care Information Centre (HSCIC) show that staff sickness absence between July 2017 and September 2017 for mental and learning disability services was 4.69% and for the NHS in England was 4.0%.

Our top reasons for sickness absence continue to be mental health related absences and muscular-skeletal (MSK) related absence. There are similar national trends in these areas and this is where we are focusing our efforts to support staff and improve attendance.

The tables below show our sickness absence rate during 2017/18 and also present some statistics around the number of days lost due to sickness absence.

Table 2.5I – Sickness absence (percentage for 2017/18)

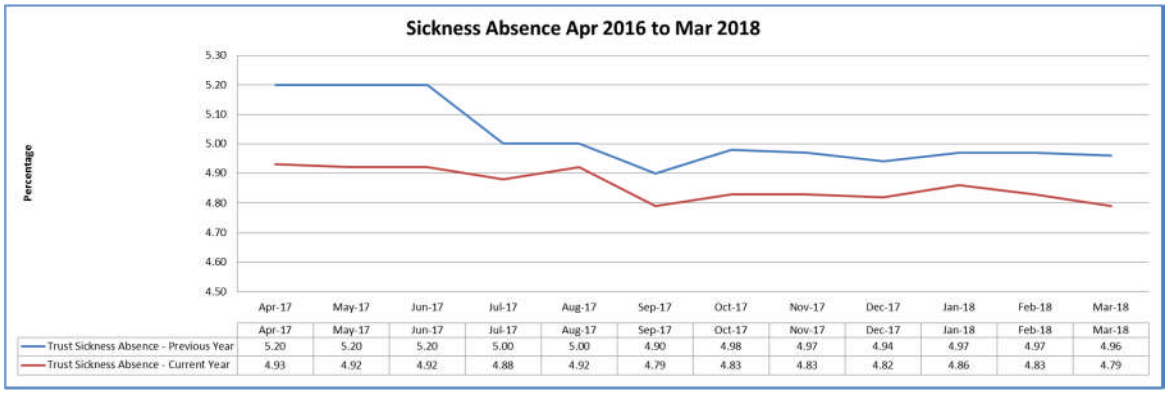


Table 2.5J – Sickness absence as reported in the FTCs	2018 (calendar year) Number
Total days lost	24,418
Total staff years	2,286
Average days lost	11

Currently we report and manage absence through the Firstcare absence reporting system. This system provides a single point of access for sickness reporting and support for managers in understanding absence rates. It allows quicker referral rates to Occupational Health, a more effective return to work process and more consistent reporting. We are currently reviewing the benefits of maintaining this separate absence management system.

We continue to provide a 24/7 Employee Assistance Programme to support staff both from a work and personal perspective which includes counselling support. All staff members can access Personal Resilience Workshops looking at skills, strategies and insights that help their resilience grow. Our stress pathway online toolkit is being further developed and we have a dedicated Well-being Practitioner supporting staff and managers to prevent and manage work-related stress.

Our physiotherapy service is well established and we are seeing a decrease in MSK absences. We have implemented physiotherapy clinics and continue to provide education and advice to prevent injury / absence where possible. The service has worked in partnership to improve our in-house training provision in the areas of moving and handling and the prevention and management of violence and aggression. We also offer a telemedicine model to triage symptoms and offered first-line advice and support. We offer physical health checks for blood pressure, blood sugar, cholesterol, and body composition along with a lifestyle questionnaire with advice being offered and onward referral to GPs where appropriate and these were very well received at a series of well-being events across the Trust where we promoted these services.

Our strategic approach to health and wellbeing is led by the Trust's Health and Wellbeing Group which implements and monitors the Health and Wellbeing Action Plan. This Action Plan is also designed to support the achievement of the national Health Wellbeing CQUIN target. This year a proposal to introduce a scheme to support staff with their financial wellbeing has been agreed and we are currently in the phase of implementation. Throughout the year we have supported and promoted national campaigns including smoking cessation, Dry January, World Mental Health Day, National Stress Awareness Day, Work Out at Work Day, Back Care Awareness Week and the seasonal flu campaign.

To support our wellbeing agenda local Health and Wellbeing Forums are being established to obtain feedback and influence trust wide initiatives, as well as providing a voice from the frontline.

2.5.10 OCCUPATIONAL HEALTH SERVICE

We continue to share our Occupational Health Service with South West Yorkshire Partnership Foundation Trust (SWYPFT). It remains a nurse-led service created to meet the specific needs of staff in a mental health, learning disability and community services. The team now provides an overall occupational health service for 10,000 employees in the region and continues to operate service level agreements for external contracts.

During 2017/18 the main achievements include:

- The integration of a Health and Wellbeing practitioner post to lead on Health and Wellbeing initiatives for both Trusts

- Provision of health checks on a needs led basis
- Fast track appointments for work related stress and MSK issues
- Introduction of voice recognition to produce reports
- Commencement of work with Bradford District Care Trust to provide Occupational Health Services from 1 July 2018

2.5.11 HEALTH AND SAFETY

We are committed to ensuring the health, safety and welfare of our employees. We also fully accept our responsibility for others who may be affected by our work activities. Health and safety is managed proactively, on the basis of risk assessment, with the aim of minimising the potential for injury and ill health.

We have in post competent people to provide specialist assistance in managing health and safety matters, including the Health, Safety and Food Safety Manager, the Senior Nurse Infection Control and the Fire Safety Advisor. This is supported by other departments who provide specific training to help reduce risks to our employees; this includes Moving, Handling and Postural Care, Prevention and Management of Violence and Aggression, Resuscitation and First Aid.

Union-appointed safety representatives have an important and valued role in representing the interests of all staff (including those who are not in a trade union), consulting with management and supporting our health and safety arrangements. Their rights as safety representatives are outlined in the Safety Representatives: Consultation with Employees Policy. We have an active Health and Safety Committee which includes an executive director who shares the joint chair arrangements with the Staffside Chair for UNISON. Members of the committee include both managers and safety representatives. We also have a joint executive level Staffside meeting chaired by the HR department, which leads the health, safety and wellbeing agenda across the organisation.

We recognise that we have a responsibility and a duty of care to provide a safe and secure environment, free from the risks of crime that may arise when providing a public service. This includes the protection of service users, staff, visitors and their property, and the physical assets of the organisation. We have an appointed Local Security Management Specialist who has responsibility for investigating all security breaches, creating a pro-security culture within our Trust and liaising with our external stakeholders (e.g. other NHS Trusts, Police and the CPS).

Managers are responsible for providing a safe working environment and for ensuring the health, safety and welfare of employees, volunteers and others within the services for which they have managerial control. The Trust has undertaken the following audits and inspections between April 2017 and March 2018:

- 48 health and safety audits
- 27 health and safety inspections
- 25 food safety audits
- 76 fire safety audits
- 3 local security reviews.

Managers also have a responsibility for the safety of service users, carers and members of the public accessing our premises. Assessing what is ‘reasonably practicable’ requires managers to make balanced and pragmatic decisions, based on considerations of the level of risk against the cost and practicality of action necessary to reduce the risk.

The Estates and Facilities Department has a special responsibility to ensure that health and safety issues are fully considered in the design and maintenance of our premises.

2.5.12 COUNTER-FRAUD

During 2017/18 the Local Counter Fraud Specialist Service (LCFS) was provided by NHS Audit Yorkshire. Audit Yorkshire specialises in all aspects of internal audit and counter fraud work, primarily

across the NHS but also the public, corporate and not for profit sectors. Audit Yorkshire has a team of accredited and experienced LCFS personnel.

Our LCFS has conducted work across all areas of counter-fraud activity, placing emphasis on the continued development of fraud awareness within our Trust and the prevention of fraud. Presentations at staff induction sessions and to selected groups of staff have been undertaken. The LCFS has continued to be proactive in their work and our staff have continued to be alerted to potential fraud risks.

During 2017/18 advice has been provided to the Trust on a number of allegations of possible fraudulent behaviour and the LCFS has continued to work closely with departments around the Trust to ensure that fraud risks are minimised.

2.5.13 AVERAGE STAFF NUMBERS

Table 2.5K – Average staff numbers for 2017/18

Average number of employees (Whole Time Equivalent basis)	Permanent (Number)	Other (Number)	Total Number (2017/18)	Total Number (2016/17)
Medical and dental	169	25	194	195
Administration and estates	549	61	610	615
Healthcare assistants and other support staff	553	233	786	799
Nursing, midwifery and health visiting staff	688	48	736	735
Scientific, therapeutic and technical staff	278	29	307	306
Social care staff	1	0	1	2
Total average numbers	**2,238**	**396**	**2,634**	**2,651**
Of which: Number of employees (WTE) engaged on capital projects	0	0	0	0

2.5.14 GENDER PROFILE OF OUR TRUST

In accordance with the Companies Act 2006 Paragraph 414C (8)(c) below is the gender profile of our organisation.

Table 2.5L – Gender profile of our Trust

Group	Number male	Number female
Directors	3	10
Senior managers (Band 8 and above)	69	141
Employees	643	1694

For the purpose of this disclosure 'senior managers' are defined as all Agenda for Change staff on band 8 and above, as these individuals are deemed to have responsibility for planning, directing or controlling the activities of the organisation or a strategically significant part of the organisation as defined in the Companies Act 2006, Paragraph 414C (9)(a).

Information in section 2.5.15 is subject to audit by our external auditors, KPMG LLP.

2.5.15 ANALYSIS OF STAFF COSTS

Table 2.5M – Analysis of staff costs for 2017/18

Average number of employees (Whole Time Equivalent basis)	Permanent (£000)	Other (£000)	Total £000 (2017/18)	Total £000 (2016/17)
Salaries and wages	75,755	9,238	84,993	83,991
Social security costs	8,265	0	8,265	7,581
Employer's contributions to NHS pensions	10,535	0	10,535	10,405
Temporary staff		4,470	4,470	4,791
Total gross staff costs	**94,555**	**13,708**	**108,263**	**106,768**
Recoveries in respect of seconded staff	(523)	0	(523)	(565)
Total staff costs	**94,032**	**13,708**	**107,740**	**106,203**
Of which: Costs capitalised as part of assets	0	0	0	0

2.5.16 OFF-PAYROLL ENGAGEMENTS

The Trust's policy in relation to off-payroll engagements is as follows:

Off-payroll arrangements are those where individuals, either self-employed or acting through a personal service company, are paid gross. While off-payroll arrangements may sometimes be appropriate for those engaged on a genuinely interim basis, they are not appropriate for those in management positions or those working for a significant period with the same employer.

The Trust acknowledges that off-payroll engagements may sometimes be appropriate and beneficial. It is therefore important that these engagements are transparent and are open to scrutiny in the event of challenge.

Off-payroll engagements should only be made via the Procurement Team, with an authorised requisition and purchase order in place. Under no circumstances should Trust employees engage with any agency or individual (Personal Service Company) directly without consultation with the Procurement Team.

In all circumstances appropriate contracts and/or framework agreements should be in place between the Trust and either the individual, agency or personal service company. All contracts and/or framework agreements should include a clause giving the Trust the right to seek assurance in relation to income tax and national insurance.

In addition, the appointing manager is required to undertake a risk assessment as to whether or not assurance needs to be sought that the individual is paying the right amount of tax and national insurance. This applies to all circumstances and a pro-forma for this is included in the policy.

The following table sets out all off-payroll engagements as at 31 March 2018 where the individual is paid more than £245 per day and where the engagement lasts for longer than six months.

Table 2.5N

Number of existing engagements as of 31 March 2018	5
Of which:	
The number that have existed for less than one year at the time of reporting	3
The number that have existed for between two and three years at time of reporting.	2

The following table relates to all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, where the individual was paid more than £245 per day and where the engagement lasted for longer than six months.

Table 2.5O

Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	11
Number assessed as within the scope of IR35	4
Number assessed as not within the scope of IR35	7
Of which:	
Number engaged directly (via PSC contracted to trust) and are on the trust's payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

All of the above were sourced through employment agencies. Those identified as not within the scope of IR35 are not operating through a PSC and are on the agency payroll. Those operating through a PSC have been identified and confirmation sought that these engagements are compliant with the legislation.

The following table shows any off-payroll engagements of Board members and/or senior officials with significant financial responsibility between 1 April 2017 and 31 March 2018.

Table 2.5P

No. of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year	0
No. of individuals that have been deemed "board members and/or senior officials with significant financial responsibility" during the financial year. This figure should include both off-payroll and on-payroll engagements.	16

2.5.17 STAFF EXIT PACKAGES

These reporting requirements cover the total costs of exit packages agreed in the year. They include payments under the Civil Service Compensation Scheme (CSCS), payments under any other compensation schemes where applicable, e.g. other Non-departmental Public Bodies (NDPBs) and any other payments made.

Exit packages for Board members are included above with further detail in the Directors' Remuneration Report. There were no exit packages relating to Board members in 2017/18 (0 in 2016/17).

Table 2.5Q

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
Less than £10,000	0 (0)	3 (4)	3 (4)
£10,001 - £25,000	2 (0)	4 (0)	6 (0)
£25,001 - £50,000	4 (0)	4 (0)	8 (0)
£50,001 - £100,000	2 (1)	2 (0)	4 (1)
£100,001 - £150,000	1 (0)	0 (0)	1 (0)
£150,001 - £200,000	0 (0)	0 (0)	0 (0)
Greater then £200,000	0 (0)	0 (0)	0 (0)
Total number of exit packages by type	**9 (1)**	**13 (4)**	**22 (5)**
Total resource cost (£000)	**449 (50)**	**332 (20)**	**781 (70)**
		Note: Figures in brackets relate to 2016/17	

2.5.18 NON-COMPULSORY / OTHER DEPARTURES AGREED

Table 2.5R

	Agreements (Number)	Total value of agreements (£000)
Voluntary redundancies including early retirement contractual costs	0 (0)	0 (0)
Mutually agreed resignations (MARS) contractual costs	9 (1)	296 (4)
Early retirements in the efficiency of the service - contractual costs	0 (0)	0 (0)
Contractual payments in lieu of notice	4 (3)	36 (16)
Exit payments following Employment Tribunals or court orders	0 (0)	0 (0)
Non-contractual payments requiring HMT approval	0 (0)	0 (0)
Total	**13 (4)**	**332 (20)**
Of which: Non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	0 (0)	0 (0)
	Figures in brackets relate to 2016/17	

As a single exit package can be made up of several components, each of which will be counted separately in this note, the total number above may not necessarily match the total numbers in Table 2.5M (staff exit packages), which will be the number of individuals.

Non-contractual payments requiring HMT approval includes any non-contractual severance payment made following judicial mediation and any non-contractual payments in lieu of notice. In 2017/18, the maximum payment was £146,667 and the minimum payment was £1,997. The median of the payments was £27,753.

The Remuneration Report provides specific details of exit payments payable to individuals named in that report.

2.5.19 EXPENDITURE ON CONSULTANCY

Details of our expenditure on consultancy can be found in Note 5 of the Annual Accounts in Part C of Annual Report.

SECTION 2.6 – ACCOUNTABILITY REPORT (Disclosures required in the Annual Report)

2.6.1 COMPLIANCE WITH THE CODE OF GOVERNANCE

The Board has overall responsibility for the administration of sound corporate governance throughout the organisation. The NHS Foundation Trust Code of Governance (the Code) is published by NHS Improvement (previously Monitor). The purpose of the Code is to assist foundation trust boards with ensuring good governance and to bring together best practice from public and private sector corporate governance.

2.6.1.1 Comply or explain

The Code is issued as best practice, but also contains a number of main principles, supporting principles and code provisions on a 'comply or explain' basis. The Leeds and York NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance issued in 2012, most recently revised in July 2014. This is based on the principles of the UK Corporate Governance Code.

A full review of compliance with the Code is submitted to the Audit Committee on an annual basis to support this statement. A copy of the full report to the Audit Committee is available on request from the Head of Corporate Governance. The Trust carried out a detailed self-assessment against the requirements of the Code and submitted the assessment to the Audit Committee for approval and to support this statement that the Trust continues to comply with the principles of the Code with the exceptions as listed in the table below.

Table 2.6A – Areas of non-compliance or limited compliance with the provisions of the Code of Governance

Code provision	Requirement	Explanation
D.2.2	The Remuneration Committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management.	The Remuneration Committee sets the pay for executive directors both at the point of advertising for a vacancy and then periodically if required to do so. The Remuneration Committee has also agreed that the pension rights for executive directors are determined by the NHS pension scheme not by itself.

2.6.2 DISCLOSURE STATEMENTS TO BE MADE IN THE ANNUAL REPORT

The Code contains a number of disclosure statements that the Board is required to include in the Annual Report. The disclosure statements contained in the Annual Report are based on the 2014 version of the Code of Governance, and the table below shows how the Board has complied with those disclosures that it is required to include in this Annual Report.

The table below also includes a small number of specific additional requirements as set out in the NHS Foundation Trust Annual Reporting Manual, which directly relate to, or enhance the annual reporting requirements as set out in the NHS Foundation Trust Code of Governance.

Table 2.6B – How we have complied with the disclosures we are required to report on in the Annual Report

Code provision	Requirement	Section in Annual Report / explanatory statement
A.1.1	The schedule of matters reserved for the Board of Directors should include a clear statement detailing the roles and responsibilities of the Council of Governors. This statement should also describe how any disagreements between the Council of Governors and the Board of Directors will be resolved. The Annual Report should include this schedule of matters or a summary statement of how the Board of Directors and the Council of Governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the Board of Directors.	• Section 3.1 (Board of Directors) • Section 4.4 (Council of Governors)
A.1.2	The Annual Report should identify the: • Chairperson and the deputy chairperson (where there is one) • Chief Executive • Senior Independent Director • Chairperson and members of the Nominations Committee and the number of meetings and attendance by directors • Chairperson and members of the Audit Committee and the number of the meeting and attendance by directors • Chairperson and members of the Remuneration Committee and the number of the meeting and attendance by directors • Number of meetings of the Board and individual attendance by directors.	• Section 2.1.1 • Section 2.1.1 • Section 2.1.1 • Section 2.4.4.4 • Table 3C in Section 3.6 • Section 2.4.4.2 • Section 3.4
A.5.3	The Annual Report should identify: • The members of the Council of Governors • A description of the constituency or organisation that governors represent, whether they were elected or appointed, and the duration of their appointments • The nominated lead governor.	• Tables 4B and 4C in Section 4.1 • Table 4B and 4C in Section 4.1 • Section 4.1
Annual Reporting Manual additional disclosure	The Annual Report should include a statement about the number of meetings of the Council of Governors and individual attendance by governors and directors.	• Table 4G in Section 4.3 and table 4H in Section 4.5
B.1.1	The Board of Directors should identify in the Annual Report each non-executive director it considers to be independent, with reasons if necessary.	• Section 2.1.1
B.1.4	The Board of Directors should include in its Annual Report a description of each director's skills, expertise and experience. Alongside this, in the Annual Report, the Board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.	• Section 3.3 • Section 2.1.1
Annual Reporting Manual additional disclosure	The Annual Report should include a brief description of the length of appointments of the non-executive directors, and how they might be terminated.	• Section 2.1.1
B.2.8	The Annual Report should describe the process followed by the Council of Governors in relation to appointments of the chairperson and non-executive directors.	• Section.2.4.4.3

Code provision	Requirement	Section in Annual Report / explanatory statement
B.2.10	A separate section of the Annual Report should describe the work of the Nominations Committee(s), including the process it has used in relation to Board appointments.	• Section 2.4.4.3 (Appointments and Remuneration Committee) • Section 2.4.4.4 (Nominations Committee)
Annual Reporting Manual additional disclosure	The disclosure on the work of the Nominations Committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of the chair or non-executive director.	Not applicable, open advertising and external search companies are used in each NED recruitment campaign.
B.3.1	A chairperson's other significant commitments should be disclosed to the Council of Governors before appointment and included in the Annual Report. Changes to such commitments should be reported to the Council of Governors as they arise, and included in the next Annual Report.	• Section 2.1.1 and 3.3
B.5.6	Governors should canvass the opinion of the Trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the Board of Directors. The Annual Report should contain a statement as to how this requirement has been undertaken and satisfied.	• Section 1.1.5.2
Annual Reporting Manual additional disclosure	If during the financial year the governors have exercised their power under paragraph 10c of Schedule 7 of the NHS Act 2006 then information on this must be included in the Annual Report (power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance).	This power has not been exercised during the course of the financial year
B.6.1	The Board of Directors should state in the Annual Report how performance evaluation of the • Board • Board committees • Directors including the chairperson, has been conducted.	• Section 2.4.3.2 • Section 3.5.2 • Section 2.4.3.2
B.6.2	Where there has been external evaluation of the board and or governance of the Trust, the external facilitator should be identified in the Annual Report and a statement made as to whether they have any other connection to the trust.	• Section 2.1.8
C.1.1	The directors should explain in the Annual Report their responsibility for preparing the Annual Report and accounts, and state that they consider the Annual Report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy.	• Part C Section 2.1
C.1.1	Directors should also explain their approach to quality governance in the Annual Governance Statement (within the Annual Report).	• Section 2.9 and Section 2.1.8

Code provision	Requirement	Section in Annual Report / explanatory statement
C.2.1	The Annual Report should contain a statement that the Board has conducted a review of the effectiveness of its system of internal controls.	• Section 2.9 (Annual Governance Statement)
C.2.2	The trust should disclose in the Annual Report if it has an internal audit function, how the function is structured and what role it performs.	• Section 6.2
C.3.5	If the Council of Governors does not accept the Audit Committee's recommendation on the appointment, re-appointment or removal of an external auditor, the Board of Directors should include in the Annual Report a statement from the Audit Committee explaining the recommendation and should set out reasons why the Council of Governors has taken a different position.	Not applicable there was no appointment of the auditors made during 2017/18
C.3.9	A separate section of the Annual Report should describe the work of the Audit Committee in discharging its responsibilities. The report should include: • The significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed • An explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted • If the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	• Section 3.6
D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the Annual Report should include a statement of whether or not the director will retain such earnings.	Not applicable
E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the Annual Report.	• For governors, section 5.5 and also details on the contacts page of the report • For directors see details on the contacts page of the Annual Report
E.1.5	The Board of Directors should state in the Annual Report the steps they have taken to ensure that the members of the Board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the Council of Governors, direct face-to-face contact, surveys of members' opinions and consultations.	• Section 4.5
E.1.6	The Board of Directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the Annual Report.	• Sections 5.3 and 5.4

Code provision	Requirement	Section in Annual Report / explanatory statement
Annual Reporting Manual additional disclosure	The Annual Report should include: • A brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership • Information on the number of members and the number of members in each constituency • A summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership [see also E.1.6 above], including progress towards any recruitment targets for members.	• Section 5.1 • Section 5.2 • Section 5.4
Annual Reporting Manual additional disclosure	The Annual Report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS foundation trust. As each NHS foundation trust must have registers of governors' and directors' interests which are available to the public, an alternative disclosure is for the Annual Report to simply state how members of the public can gain access to the registers instead of listing all the interests in the Annual Report.	• Governors = Section 4.7 • Directors = Section 2.1.2

2.6.3 DISCLOSURES AS PER SCHEDULE 7 OF THE LARGE AND MEDIUM SIZED COMPANIES AND GROUPS REGULATIONS 2008

This section sets out those disclosures required as per Schedule 7 of the Large and Medium Sized Companies and Groups Regulations 2008 and where these have been reported.

Table 2.6C – Disclosures and where they are reported in the Annual Report

Disclosure requirement	Statutory reference	Section in which reported
Any important events since the end of the financial year affecting the NHS foundation trust	7(1) (a) Schedule 7	Not applicable
An indication of likely future developments	7(1) (b) Schedule 7	• Section 2.2.1
An indication of any significant activities in the field of research and development	7(1) (c) Schedule 7	• See the Quality Report
An indication of the existence of branches outside the UK	7(1) (d) Schedule 7	Not applicable, no disclosure required
Policies applied during the financial year for giving full and fair consideration to applications for employment made by disabled persons, having regard to their particular aptitudes and abilities	10(3) (a) Schedule 7	• Section 2.5.2
Policies applied during the financial year for continuing the employment of, and for arranging appropriate training for, employees who have become disabled persons during the period	10(3) (b) Schedule 7	• Section 2.5.2
Policies applied during the financial year for the training career development and promotion of disabled employees	10(3) (c) Schedule 7	• Section 2.5.2
Actions taken in the financial year to provide employees systematically with information on matters of concern to them as employees	11(3) (a) Schedule 7	• Section 2.5.4 • Section 2.5.7

Disclosure requirement	Statutory reference	Section in which reported
Actions taken in the financial year to consult employees or their representatives on a regular basis so that the views of employees can be taken into account in making decisions which are likely to affect their interests	11(3) (b) Schedule 7	• Section 2.5.7
Actions taken in the financial year to encourage the involvement of employees in the NHS foundation trust's performance	11(3) (c) Schedule 7	• Section 2.5.4 and 2.5.7
Actions taken in the financial year to achieve a common awareness on the part of all employees of the financial and economic factors affecting the performance of the NHS foundation trust	11(3) (d) Schedule 7	• Section 2.5.7
In relation to the use of financial instruments, an indication of the financial risk management objectives and policies of the NHS foundation trust and the exposure of the entity to price risk, credit risk, liquidity risk and cash-flow risk, unless such information is not material for the assessment of the assets, liabilities, financial position and results of the entity	6 Schedule 7	• Section 1.2.2

2.6.4 OTHER DISCLOSURES AS REQUIRED BY THE NHS FOUNDATION TRUST ANNUAL REPORTING MANUAL 2017/18 AS DETERMINED BY NHS IMPROVEMENT

The Annual Reporting Manual for 2017/18 requires a number of disclosures to be made in the Annual Report and to state where these have been reported on. The following table sets out where these disclosures have been made.

Table 2.6D – Disclosures and where they are reported in the Annual Report

Disclosure requirement	Section in which reported
Any new or significantly revised services	• Section 2.2.1
Service improvements following staff or patient surveys	• Section 2.2.2.1 (for service users) • Section 2.5.5.1 (for staff)
Improvements in patient / carer information	• Section 2.2.2.1
Information on complaints	• Section 2.2.2.2
Descriptions of significant partnerships and alliances entered into by the NHS foundation trust to facilitate the delivery of improved healthcare	• Section 2.3.1
Development of services involving other local services/agencies and involvement in local initiatives	• Section 2.3.1 and 2.3.2

SECTION 2.7 – ACCOUNTABILITY REPORT (NHS Improvement Single Oversight Framework)

2.7.1 OUR PERFORMANCE

The following tables show our regulatory performance as reported to NHS Improvement for 2017/18.

Table 2.7A – Regulatory performance

Target / Measure	At Q1 2017/18	At Q2 2017/18	At Q3 2017/18	At Q4 2017/18
Finance and Use of Resources score	2	1	1	1
Governance	Green	Green	Green	Green
SOF name and % target	**Actual performance %**	**Actual performance %**	**Actual performance %**	**Actual performance %**
Mental health scores from Friends and Family Test – % positive Target: No target	**68.09% (32/47)**	**50.00% (3/6)**	**100.00% (14/14)**	**90.48% (19/21)**
Admissions to adult facilities of patients under 16 years old Target: No target	**0**	**0**	**0**	**0**
Care programme approach (CPA) followup – proportion of discharges from hospital followed up within seven days – Mental Health Services Data Set Target: 95%	**94.42%**	**96.68%**	**94.33%**	**95.33%**
% clients in settled accommodation Target: No target	**62.59%**	**62.95%**	**62.67%**	**59.08%**
% clients in employment Target: No target	**10.07%**	**10.81%**	**10.72%**	**11.42%**
Data Quality Maturity Index (DQMI) – MHSDS dataset score Target: 95% (reported only from Q3 17/18)	**-**	**-**	**96.58%**	**97.14%**

2.7.2 COMMENTARY ON THE TRUST'S PERFORMANCE

In relation to the financial and use of resources score the Trust has been rated as '1'. The financial commentary is in Section 1.2.2 of Part A of this Annual Report.

During 2017/18 the Trust reported 'green' for governance. During quarter 4 of 2017/18 the Trust received a rating of 'Requires Improvement' from the Care Quality Commission. The Trust discussed this with NHS Improvement who indicated there would be no regulatory action and so the Trust's governance risk rating remained at 'green'.

During 2017/18, there have been some areas of strong performance, for example, there were no admissions of people under 16 to adult wards and the new Data Quality Maturity Index target was met from its introduction during quarter 3. This maturity index encompasses a number of data recording metrics including NHS number and ethnicity. The Trust has, particularly in the latter half of the year, raised the profile of this recording and seen improvement during quarter 4.

A new Patient Experience lead has recently been appointed to the Trust and will be focused on improving the way in which the organisation collects and encourages participation in the Friends and Family Test.

Following up service users within 7 days of discharge from an inpatient setting is monitored every week within the organisation and any breaches of 7 days investigated. Whilst more is being done to ensure the processes are consistently applied locally, it is worth noting that sometimes a follow up does not occur at the request of the service user or their family.

2.7.2.1 Segmentation

The Trust was placed in Segment 2 through the Single Oversight Framework by NHS Improvement. This means that the Trust is offered targeted support, which is voluntarily accepted, to address issues and help move the provider to Segment 1.

The Trust continues to have robust measures in place to monitor performance and quickly address areas of concern. Each care group management team meets with individual services to review performance against key national, contractual and local targets on a regular basis. This is supported by joint operational meetings and reviews of performance at Executive Team and Trust Board level monthly.

CONFIRMATION FROM THE CHIEF EXECUTIVE

As Chief Executive I confirm that the information in this Accountability Report (made up of sections 2.1 to 2.7 of this Annual Report) is accurate to the best of my knowledge and that I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Signed Date: 24 May 2018

Dr Sara Munro
Chief Executive

SECTION 2.8 – STATEMENTS

2.8.1 STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTING OFFICER OF LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

The National Health Service Act 2006 (NHS Act 2006) states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Leeds and York Partnership NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Leeds and York Partnership NHS Foundation Trust and of its income and expenditure, items of other comprehensive income and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health Group Accounting Manual and the NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- assess the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and use the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error and for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities. The accounting officer is also responsible for ensuring that the use of public funds complies with the relevant legislation, delegated authorities and guidance.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Signed  Date: 24 May 2018

Dr Sara Munro
Chief Executive

SECTION 2.9 – ANNUAL GOVERNANCE STATEMENT

This statement seeks to make assurances about the framework of internal controls put in place to identify and manage risk for the period 1 April 2017 to 31 March 2018.

2.9.1 SCOPE OF RESPONSIBILITY

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

2.9.2 THE PURPOSE OF THE SYSTEM OF INTERNAL CONTROL

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Leeds and York Partnership NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Leeds and York Partnership NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the Annual Report and Accounts.

2.9.3 CAPACITY TO HANDLE RISK

The Board of Directors has overall responsiblility for the governance of the Trust. It provides high-level leadership for risk management. The directors (both executive and non-executive) have appropriate skills and experience to carry out this function effectively and each member of the Board of Directors has corporate and joint responsibility for the management of risk across the organisation.

The Board is responsible for reviewing the effectiveness of the system of internal control, including systems and resources for managing all types of risk. A Board sub-committee structure includes the: Quality Committee, Finance and Performance Committee, Mental Health Legislation Committee, Strategic Investment and Development Committee and an Audit Committee. Each has delegated responsibility for monitoring risk within their areas of responsibility, including receiving the Board Assurance Framework in accordance with their terms of reference. The Strategic Investment and Development Committee scrutinises strategic business opportunities and major capital investments.

The Director of Nursing and Professions has overall lead responsibility for the development and implementation of organisational risk management. However, all executive directors have a duty to effectively manage risk within their own area of responsibility. The Chief Financial Officer (CFO) has delegated responsibility for managing the development and implementation of financial risk (including oversight for counter-fraud). Within their portfolio, the CFO also has the role of Senior Information Risk Officer (SIRO); and the Medical Director is the Caldicott Guardian and Responsible Officer. The responsibility for risk management is communicated to all staff through their job descriptions and the compulsory training module.

2.9.3.1 Staff training

The organisation provides compulsory training for all staff to complete in order to comply with internal, legislative and regulatory standards. The composition of compulsory training programmes for different groups of staff have been risk assessed to ensure these are targeted, and that appropriate packages of training are in place. We have a process for monitoring the uptake of compulsory

training through a system called iLearn. The Workforce and Organisational Development Group oversees performance, and assurance reports are made to the Quality Committee and to the Board of Directors on performance against our target measure.

Risk management training and awareness is included in the compulsory health and safety training and is supported by local induction. The Trust's risk management team delivers specific risk management training at all levels across the Trust.

The Board also receives training on risk through bespoke training sessions provided by external companies with specialist knowledge.

2.9.3.2 Incident reporting and capacity to learn

The Trust actively encourages an open and honest culture of reporting incidents, risks and hazards. It also encourages staff to report instances of fraud (and suspected fraud). It uses all such reports as an opportunity to learn and improve.

In July 2017 the Learning from Mortality and Incidents Meeting (LIMM) led to a change in some of our processes. In particular, incidents of severity 3 and above are now being reviewed on a weekly basis, with support offered to the relevant teams and any learning established including good practice.

LIMM reviews all deaths and codes them in accordance with the Mazar tool. The group decides the required level of investigation and monitors its progress through the relevant forums in the Trust's governance structure.

The work of LIMM identifies themes and trends and will provide, where appropriate, more depth to the mortality review process and reduce variation in reviews. LIMM is a sub-committee to the Trust Incident Review Group (TIRG) and reports to it accordingly.

The Trust Incident Review Group (TIRG) has responsibility for reviewing in detail all incidents reported as serious, for agreeing that the recommendations and actions are appropriate.

The Trust also seeks to learn from good practice (both internal and external to the Trust) through a range of mechanisms including: benchmarking; clinical supervision and reflective practice; individual and peer reviews; continuing professional development programmes; clinical audit; and the application of evidence-based practice. Points of learning from any of these sources and potential changes in clinical practice are reviewed as necessary by the Trustwide Clinical Governance Group with assurances being made to the Board through the Quality Committee.

2.9.3.3 NHS Litigation Authority risk management standards

The Trust is committed to the effective and timely investigation of any claims and sunsequent response to any claim. The Trust is a member of NHS Resolution (previously NHS Litigation Authority) claims management scheme. As a member, it respects the requirements and notes the recommendations of the Department of Health and the NHS Resolution and its claim handling schemes.

- Clinical negligence claims are covered by the NHS Resolution Clinical Negligence Scheme for Trusts (CNST). The CNST handles all clinical negligence claims against the Trust. The Trust is the legal defendant, however, the NHSR takes over full responsibility for handling the claim and meeting the associated costs
- Employer liability claims are covered by the NHS Resolution Risk Pooling Scheme for Trusts (RPST) and Liability to Third Parties Scheme (LTPS). LTPS covers employers' liability claims, from straightforward slips and trips in the workplace to serious manual handling, bullying and stress claims. In addition LTPS covers public and products liability claims, from personal injury sustained by visitors to NHS premises to claims arising from breaches of the Human Rights Act, the Data Protection Act and the Defective Premises Act
- Public liability claims are handled as above
- Claims in respect of loss or damage to Trust property are covered by the NHS Resolution RPST Property Expenses Scheme (PES).

2.9.3.4 Work performed to assess Well-led

In January 2017, the Board asked Deloitte LLP to carry out an independent review of our governance arrangements against the well-led framework. The Board decided to do this so it had assurance that the Trust met the standards of good practice.

The first phase of the review looked at sub-Board level structures and processes i.e. structures and processes at executive director (corporate) through to directorate (care service) level.

In May 2017, Phase 1 was concluded. Deloitte found a lot of good practice in the Trust, but they also made a number of recommendations. These were accepted by the Board and an action place was drawn up which was fully implemented in 2017/18. Executive director leads were identified for each action and progress was monitored through the Senior Leadership Team meetings.

Phase 1 looked at the arrangements over three main headings:

- Corporate and divisional leadership capacity and capability
- Corporate governance structures roles and accountabilities
- Accountability and performance management arrangements.

The changes made strengthened our internal governance arrangements and make it clear where decisions are taken and where risks or issues are escalated to; where accountability sits and what assurance looks like. The changes also ensure that we are clear about the performance measures we need to report against and where these are reported to.

Phase 2 of the review was completed in September 2017. It looked at Board and committee effectiveness. This focused on areas not covered in Phase 1 and included:

- Strategic development and oversight
- Organisational culture
- Committee effectiveness
- Performance information.

The Phase 2 action plan was monitored by the Executive Management Team and the Board.

The key arrangements in place to ensure we are well-led are:

- An experienced leadership team with the skills, abilities, and commitment to provide high-quality services. We recognise the training needs of managers at all levels, including those of the leadership team, and provide development opportunities for the future of the organisation
- The board and senior leadership team has set a clear vision and values that are at the heart of all the work within the organisation and we ensure staff at all levels understand them in relation to their daily roles
- The newly developed trust strategy is directly linked to the vision and values of the trust and we have involved stakeholders in the development of the strategy. We also have five strategic plans which have been aligned to each other and to the delivery of the strategy.
- Senior leaders visit all parts of the trust and feed back to the board to inform the discussion in relation to the challenges staff and the services face
- We are actively engaged in collaborative work with external partners including NHS partners, primary care, local authorities, the voluntary sector, and the local transformation plans
- The Board has sight of the most significant risks and mitigating actions through the Board Assurance Framework
- Appropriate governance arrangements are in place in relation to Mental Health Act administration and compliance
- We have a structured and systematic approach to staff engagement

- The Board reviews performance reports that include data about the services. We also have an Executive Performance Overview Group which allows executive directors and service managers and staff to be sighted on their key performance indicators and any issues to delivery
- We are committed to improving services by learning from when things go well and when they go wrong; we also promote research and innovation.

2.9.4 THE RISK AND CONTROL FRAMEWORK

The Trust has in place a comprehensive Risk Management Policy which is available to all staff on Staffnet. The purpose of this policy is to ensure that the Trust manages risks in all areas using a systematic and consistent approach. It provides the framework for a robust risk management process throughout the Trust. The document describes the Trust's overall risk management process and the Trust's risk identification, evaluation and control system.

All risks are assessed using an electronic system for recording and managing risk assessments, which can be accessed through Staffnet. This system is used by staff to assess and record risk assessments, scoring risks using a 5 x 5 assessment of likelihood and impact. Risks are then captured on the appropriate risk register which could be local, directorate, corporate or strategic. A monthly Executive Risk Management Group meeting takes place, chaired by the Chief Executive, which monitors risk registers. A dashboard is provided to highlight any risks or actions beyond their due date.

Clinical risk management is based on a structured clinical assessment model under-pinned by CPA and supported by decision-making aids.

Business, financial and service delivery risks are derived from organisational objectives through the business planning process. Clinical and non-clinical risks are identified through a well-defined process of assessment and reporting.

2.9.4.1 The Board Assurance Framework

The Board Assurance Framework (BAF) is one of the key risk assurance tools for the Board. It contains the principal risks to the achievement of the organisation's strategic objectives, which are taken from the strategic risk register. The BAF enables the Board, primarily through its Board sub-committee structure, to monitor the effectiveness of the controls required to minimise the principal risks to the achievement of the Trust's objectives and therefore provides evidence to support this Annual Governance Statement.

The BAF was refreshed in 2017/18 both in terms of its format and content. This is formally reviewed by the Board on a quarterly basis and the Audit Committee at least twice a year. The relevant sections of the BAF are also reviewed by the Board sub-committees on a quarterly basis for those risks where they are named as assurance receivers. The BAF has been audited in-year and found to be fit-for-purpose with 'significant assurance' being given to its governance process.

2.9.4.2 Quality governance arrangements

The Trust has established a Governance, Accountability, Assurance and Performance Framework which sets out the organisation's overarching principles and approach to delivering a quality service in a high performing organisation. The framework aims to ensure the Trust successfully delivers national standards for governance and performance through clear lines of accountability.

The framework describes how the Trust will use improved information management, alongside clear governance and accountability in order to deliver better performance. This will be achieved through the introduction of a tiered performance management process which demonstrates rigour, support, challenge, timely escalation and a consistent approach to clinical governance and performance management at all levels of the organisation. It uses the approach set out in the Single Oversight Framework from NHS Improvement (November 2017).

The underpinning principles of the framework are also aligned with the Trust's strategy, values and behaviours and the Care Quality Commission's Key Lines of Enquiry (KLoE).

The Trust is registered with the CQC and is fully compliant with the registration requirements. Compliance with the Care Quality Commission (CQC) essential standards of quality and safety are one of the elements of the organisation's risk management process.

To manage any risk of non-compliance with the CQC registration the Trust has established a CQC Project Group which meets monthly to monitor progress against the CQC action plan and to identify any risks which require immediate action. All actions and supporting evidence would have previously been agreed and signed off in the relevant Clinical Governance Forum. The Trust has a Quality Review process to support all areas to attain a rating of 'good' or 'outstanding'. There are also monthly discussions between the Nursing Leadership Team and the CQC link officers and a quarterly meeting between the Director of Nursing and Professions and the CQC officers linked with the Trust.

We will take a Trustwide view of the themes from our CQC inspections and take a holistic approach to resolving these issues and reducing risks of non-conformity across the Trust. We ensure that the programme of activities and projects are working together and that benefits and improvements are brought to all core services.

The Trust has a bespoke electronic activity tracker which is a tool to monitor deadlines, record evidence of actions and evidences in which governance meeting the action was signed off. This provides an audit trail and assurance for the CQC Group who then make assurance reports to the Quality Committee and in turn the Board.

The Trust has a programme of Peer Reviews throughout the year to improve, share and embed best practice around the Trust. The Peer Reviews are based around the CQC Key Lines of Enquiry (KLoE). Membership of the Peer Review teams changes and is shared between core services to ensure transparency and to spread the learning amongst staff. During these reviews we identify risks to service delivery and use the evidence to make processes and procedures easier to comply with.

2.9.4.3 Fraud, corruption and bribery

The Trust has procedures in place that reduce the likelihood of fraud, corruption and bribery occurring. These include an Anti-fraud and Bribery Procedure, Standing Orders, Standing Financial Instructions, documented procedures, a system of internal control (including internal and external audit) and a system of risk assessment. In addition, the Trust seeks to ensure that a comprehensive anti-fraud, corruption and bribery culture exists throughout the Trust via the appointment of a dedicated Local Counter-fraud Specialist in accordance with the standards set out in the provider contracts.

Our LCFS has conducted work across all generic areas of counter-fraud activity, placing emphasis on the continued anti-fraud culture within our Trust and the prevention of fraud. Presentations at staff induction sessions and to selected groups of staff have been undertaken. The LCFS has continued to be proactive in their work and our staff have continued to be alerted to potential and real fraud risks.

2.9.4.4 Principal risks to compliance with licence Condition 4.2 of FT4 (FT Governance)

The Trust has put in place measures to ensure that the Board is able to confirm compliance with Licence Condition 4.2 of FT4 (FT Governance) i.e. that we apply systems and standards of good corporate governance expected of a supplier of health services. Our arrangements include a governance structure with four locally-determined Board sub-committees, over and above those required in statute (the Quality Committee, the Finance and Performance Committee, the Mental Health Legislation Committee and the Strategic Investment and Development Committee). This ensures that members of the Board (particularly non-executive directors) are more closely involved in the governance of the organisation and assurance on the quality of services (clinical and non-clinical). There is also a structure beneath the Executive Management Team to support executive directors in delivering their individual portfolios to support the Chief Executive in carrying out their duties as Accounting Officer.

The Board of Directors and its sub-committees have agreed terms of reference setting out accountabilities and the delegated authority they have been given by the Board to carry out work on its behalf. The Trust has in place all the necessary statutory documentation including a constitution, a scheme of delegation and matters reserved to the Board. The Trust also has a Corporate Governance Strategy which describes the framework for corporate governance and which references all the documents that sit within that framework. All members of the Board have role descriptions, clearly setting out their duties and areas of accountability and there is a signed memorandum of understanding between the Chair and Chief Executive, setting out their respective responsibilities, all Board members have been deemed to the Fit and Proper in accordance with the CQC standard.

On a monthly basis the Board receives a Combined Quality and Performance Report that details compliance with, and achievement of, all regulatory, contractual and local targets and also provides financial information. The Board and its sub-committees receive timely and accurate information to the meetings, and in accordance with their scheduled cycles of business. Performance data relating to their areas of responsibility will be scrutinised. Performance is also reported to the Council of Governors and governors are provided with an opportunity of holding the non-executive directors to account for the performance of the Board.

In February 2017, as part of a programme to review the Trust's governance arrangements, the Board commissioned an external review of the reporting structures and mechanisms was carried out by Deloitte LLP. The aim of this review was to ensure structures and mechanisms were fit for purpose and to develop a Governance, Assurance and Accountability Framework including a clear line of sight from ward to Board and the escalation of risks and issues. This work was concluded and details of the findings are set out in Section 2.9.3.4 of this Annual Governance Statement.

2.9.4.5 Corporate Governance Statement

The Corporate Governance Statement (CGS) has been prepared in accordance with the guidance issued by NHS Improvement; its completion in 2017/18 was co-ordinated by the Head of Corporate Governance. Evidence of compliance or risks to compliance with each of the standards in the CGS was provided by a lead senior manager (identified for each condition). This was then approved by an identified director before the entire document was submitted to the executive directors for consideration and to the Audit Committee for assurance about the process. The Board received and considered the CGS at its meeting on 24 May 2018.

2.9.4.6 Stakeholders and partners

The Trust involves stakeholders and partners in identifying and managing risks to its strategic objectives in a number of ways. These include:

- Working in partnership to develop system-wide plans with stakeholders across Leeds and West Yorkshire through the STP process.
- Participating within the citywide strategic partnership group for mental health (West Yorkshire Mental Health Services Collaborative and the Committees in Common)
- Working with partners in health and social services in developing and considering business and service change. The Trust has a framework for managing change to services agreed as part of its contracts with its main commissioners. The Trust also has good relationships with Overview and Scrutiny Committees
- Active relationships with Healthwatch and service user and carer groups, working with these groups on the management of service risks and change
- Active engagement with governors on strategic, service, and quality risks and changes including active engagement in the preparation of the Quality Report and the setting of strategic priorities.

2.9.4.7 NHS Pension Scheme control measures

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme's regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments to

the scheme are in accordance with the scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the regulations.

2.9.4.8 Equality, diversity and human rights control measures

Control measures are in place to ensure that the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Board has arrangements in place to ensure that the Foundation Trust complies with the Equality Act 2010. It has approved equality objectives for 2018 to 2020 and an annual equality progress assessment is undertaken using the Equality Delivery System framework.

We have in place systems for monitoring equality progress and compliance against our objectives through the Workforce and Organisational Development Group. This includes reporting to the Quality Committee and to the Board of Directors on performance against our target measures and the publication of an annual Equality and Diversity and Human Rights Report.

Evidence that issues specific to equality and diversity have been considered is required before policy decisions are made. Equality analysis screening is required for all papers presented to governance meetings and for all new and revised procedural documents as detailed in the Trust's Procedure for the Development and Management of Procedural Documents.

2.9.4.9 Carbon reduction delivery plans

The Trust has undertaken risk assessments, and carbon reduction delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that the Trust's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

2.9.5 KEY RISKS FOR THE ORGANISATION

Key risks for the organisation are those that have been identified as strategic risks on the Strategic Risk Register. In summary these are:

- Due to an inability to align our workforce capacity to planned models of care, there is a risk that we are unable to deliver high quality, evidence based, person centred care
- We are unable to maintain compliance with regulatory requirements relating to the quality and safety of our services due to a failure to provide care in line with national standards and best practice.
- Due to inadequate systems to support continuous learning, improvement and innovation, there is a risk that our services deliver poor outcomes for service users
- We are unable to maintain effective, productive relationships with key external stakeholders, with the result that we are unable to work successfully with partners to support innovative care and exceptional outcomes for service users
- If we cannot produce and effectively use information about our services to support the operation of our governance structures, there is a risk that there will be a lack of confidence in our management information and that we will be unable to ensure the safety of our services
- We are unable to deliver an effective and attractive programme of training and development opportunities for our staff due to inadequate capability and capacity, corporately and within care services
- As a result of a culture of blame which does not foster a psychologically safe environment for our staff we are unable to reduce patient harms or provide a positive experience for our service users
- A lack of financial sustainability results in us having insufficient funds to sustain and develop our services and invest in high quality outcomes for our service users
- Due to inadequate, inflexible or poorly maintained estates and facilities we are unable to provide a safe and positive environment for service users and staff
- As a result of insecure, inadequate or unstable information technology systems and infrastructure, the quality and continuity of our services is compromised.

Each of these risks has an identified executive director and management lead. These risks will be managed through the risk management and risk register processes and reported to the Executive Risk Management Group, the Board and the relevant Board sub-committee through the Board Assurance Framework.

Behind each risk is a detailed risk assessment which sets out the controls and mitigations. The strategic risk register is reviewed by the Executive Risk Management Group via the Board Assurance Framework.

2.9.6 REVIEW OF ECONOMY, EFFICIENCY AND EFFECTIVENESS OF THE USE OF RESOURCES

We published our refreshed Trust Strategy for 2018 to 2023 in November 2017. This sets out our ambitions and plans for the next five years. In refreshing our strategy we wanted to make sure it is relevant and fully aligned with the key themes within national and local strategies that are relevant to people using our services, carers, our staff and our organisation as a whole. Of particular note is the NHS Five Year Forward View, the development of local and regional Sustainability and Transformation Partnerships, and the Mental Health Five Year Forward View. All these plans have been translated into local actions through the sustainability and transformation plans, the local Leeds plan and the Transforming Care programme for learning disability services.

Our new Trust strategy describes what we want to achieve over the next five years (to 2023) and how we plan to get there. The strategy is designed around three key elements: delivering great care; rewarding and supportive workplace; and effective and sustainable services.

Refreshing our strategy has given us the opportunity to go back to people who use our services, carers, staff and partners to determine what our key strategic objectives should be for the next five years and to help us develop a list of priorities for action.

To enable the delivery of our strategy we have developed a set of strategic plans. These are our delivery plans which provide detailed information about how we will achieve our ambitions and include our plans for: clinical services; estates; health informatics; workforce and development; and quality. Each year we set out our annual actions for achievement as part of our Operational Plan (Trust business plan and financial strategy).

The financial strategy for the coming year is set out in the Trust's one-year Operational Plan. This shows on a projected basis what the expected financial performance for the coming year is to be. There is in place a comprehensive process for developing the plan with there being consultation with the Council of Governors and sign-off by the Board of Directors prior to submission to NHS Improvement. To be assured of progress against the plan (both financial and operational) the Board receives a quarterly update, with the Executive Management Team and the Programme Management Office taking operational control.

As part of the annual planning process we are required to identify our Cost Improvement Plans (CIPs). All our CIPs have been through the standard quality and delivery impact assessment process, with a CIP pro-forma being completed for each individual scheme. Each scheme has been scored and electronically signed off by both the Medical Director and the Director of Nursing and Professions and is monitored through the Programme Management Office.

The Financial Planning Group is set up to provide routine assurance and oversight related to the quality and financial impact of existing cost improvement schemes. This group meets on a bi-monthly basis and is chaired by the Chief Financial Officer. The ongoing process of assessing the actual impact on quality and delivery is routinely undertaken by each responsible directorate management team meetings and escalated through to the Financial Planning Group. All accepted plans are presented to the Quality Committee (a board sub-committee) where assurance is provided on the rigour of the quality and delivery impact assessment process.

The Trust operates within a well-defined corporate governance framework, with financial governance being set out through a number of documents including the Corporate Governance Policy, Standing

Financial Instructions, financial procedures, the Scheme of Delegation and Matters Reserved to the Board of Directors. This framework includes explicit arrangements for:

- Setting and monitoring financial budgets
- Delegation of authority for committing resources
- Performance management
- Achieving value for money.

The Trust receives its core accounting systems and processes from third parties. The main accounting functions are provided by NHS Shared Business Services Ltd. Assurance is provided to the Trust through the Statement of Auditing Standards (SAS) No. 70, prepared by NHS Shared Business Services independent auditors. This internationally-recognised auditing standard signifies that a service organisation has had its control objectives and control activities examined by an independent accounting and auditing firm.

The payroll service is provided by the Leeds Teaching Hospitals NHS Trust (LTHT). Assurance is received from LTHT and its internal auditors regarding both the performance and controls associated with the Electronic Staff Record (ESR) system, which concludes that the payroll function is operational within an environment of effective control.

The structures that have been applied in maintaining and reviewing economy, efficiency and effective use of resources include:

- **The Board of Directors** receives reports on any significant events or matters that affect the Trust. The Board also receives the Combined Quality and Performance Report monthly which reports on performance against the Trust's regulatory, contractual and internal targets and standards both non-financial and financial; the Board Assurance Framework; progress against the Operational Plan measures; and reports from the Chairs of its sub-committees including the Audit Committee

- **Internal Audit** (NHS Audit Yorkshire) provides an independent and objective opinion on the degree to which risk management, control and governance support the achievement of the Trust's objectives. The audit plan is derived from an assessment of risk areas within the Trust and includes all areas where Internal Audit is named in the Board Assurance Framework as a provider of assurance on the effectiveness of key controls.

  In 2017/18 the Internal Audit reports issued in the year have generated an overall opinion of 'significant assurance' as detailed in the Head of Internal Audit Opinion.

  Whist an overall opinion of significant assurance has been provided, attention is drawn to the fact that there have been three reports issued in 2017/18 with a 'limited assurance' opinion which are detailed below.

    - **LY01/2018 – Implementation of NICE Guidance** – Whilst the Trust has in place a system to identify and disseminate NICE guidance there were a number of weaknesses identified in regard to: action planning; the establishment of a forum to monitor the implementation of guidance; and the information in the policies and procedures. The Trust has these actions in hand and the auditors have noted the progress made.

    - **LY03/2018 – Fire Safety Management** – The auditors found weaknesses in respect of the management processes in place, rather than there being a specific fire risk. The weaknesses were in regard to: the risk register; the documentation of the joint fire safety arrangements between the Trust and its PFI / NHS Property Services partners; completion of actions identified from fire safety audits; uptake of compulsory training; and specific training for the Board. The auditors have been assured on the progress made in the completion of the actions to address the recommendations

- **LY08/2018 – Delayed Transfer of Care (DToC) and Out of Area Placements (OAPs)** – The auditors found there to be weaknesses in relation to: the reporting mechanisms; and proactive planning for discharging service users. The auditors have recognised the work done to strengthen processes around DToCs and OAPs.

All the above areas will be audited again in 2018/19 to ensure the sufficiency of the actions taken to address areas of weakness identified by our internal auditors.

- **External Audit** (KPMG) provides audit scrutiny of the annual financial statements, and looks at the Trust's economy, efficiency and effectiveness in its use of resources. External audit also provides assurance through the review of systems and processes as part of the annual audit plan

  In 2017/18 the Trust's external audit provider changed from PricewaterhouseCoopers LLP to KPMG. Our new audit team will carry out the audit of the 2017/18 annual accounts and will provide a report on their findings (ISA 260 Report) to the Audit Committee which is the body 'charged with governance' in the Trust.

- **The Audit Committee** is a sub-committee of the Board of Directors, the membership of which is made up of non-executive directors. It reports directly to the Board. The committee has responsibility for being assured in respect of the Trust's internal controls, including risk management, and for overseeing the activities of internal audit, external audit and the local counter-fraud services.

  The committee executes this role by approving the annual plans for internal and external audit and counter-fraud; receiving reports and updates against those plans; reviewing risks through the Board Assurance Framework; carrying out deep-dives into any area where further assurance is required on an area of risk

- **Board sub-committee structure** is made up of four locally determined committees; the Quality Committee, the Mental Health Legislation Committee, the Finance and Performance Committee and the Strategic Investment and Development Committee; each of which has responsibility for assurance in areas of clinical and financial performance and compliance. The Board also has two further statutory committees: the Nominations Committee and the Remuneration Committee. Each of the Board sub-committees is chaired by a non-executive director, with the Remuneration Committee being made up wholly of non-executive directors.

2.9.7 INFORMATION GOVERNANCE

2.9.7.1 Incidents relating to information governance

Below is an analysis of our information governance incident reporting records for 2017/18. This shows 18 incidents that have sensitivity factors that classify them as a Serious Incident Requiring Investigation (SIRI), which have been reported via the national online tool.

Table 2.9A – Summary of incidents involving personal data as reported to the Information Commissioner's Office in 2017/18

Date of incident (month)	Nature of incident	Nature of data involved	Number of people potentially affected	Notification steps
April 2017	Disclosed in Error	Details about 1 patient included in paperwork given to another	1	DH / ICO notification via NHS Digital website
May 2017	Disclosed in Error	Letter sent to wrong address on same street	1	DH / ICO notification via NHS Digital website
June 2017	Disclosed in Error	Taxi transport sent to wrong address, disclosed patient ID to inappropriate person	1	DH / ICO notification via NHS Digital website
June 2017	Disclosed in Error	Patient received care plan relating to a different patient	1	DH / ICO notification via NHS Digital website
July 2017	Disclosed in Error	Letter sent to wrong address on same street	1	DH / ICO notification via NHS Digital website
September 2017	Unauthorised Access / Disclosure	Agency nurse included husband in call from police relating to witness statement	1	DH / ICO notification via NHS Digital website
September 2017	Disclosed in Error	Inappropriate disclosure of Section information to patient's mother	1	DH / ICO notification via NHS Digital website
September 2017	Disclosed in Error	E-mail about service user inappropriately copied to his mother	1	DH / ICO notification via NHS Digital website
September 2017	Unauthorised Access / Disclosure	Member of staff inappropriately brought husband into working side of building	Numerous	DH / ICO notification via NHS Digital website
September 2017	Disclosed in Error	Patient assessment sent by fax to wrong number	1	DH / ICO notification via NHS Digital website
October 2017	Disclosed in Error	Staff left files in recreation room, found by patient	2	DH / ICO notification via NHS Digital website
November 2017	Disclosed in Error	Subject Access Request sent to one patient contained miss-filed document relating to another	1	DH / ICO notification via NHS Digital website
December 2017	Disclosed in Error	Information about 1 patient sent in correspondence to another	1	DH / ICO notification via NHS Digital website
December 2017	Disclosed in Error	Information about 1 patient sent in correspondence to another	1	DH / ICO notification via NHS Digital website
December 2017	Disclosed in Error	Appointment letter sent to neighbour's address	1	DH / ICO notification via NHS Digital website

Date of incident (month)	Nature of incident	Nature of data involved	Number of people potentially affected	Notification steps
December 2017	Disclosed in Error	Letter sent to wrong address on same street	1	DH / ICO notification via NHS Digital website
December 2017	Disclosed in Error	Letter sent to wrong address on same street	1	DH / ICO notification via NHS Digital website
January 2018	Disclosed in Error	Details about one patient included in letter to another	1	DH / ICO notification via NHS Digital website
Further action taken	A local senior management fact-find has been undertaken in relation to each incident and process improvements and / or disciplinary actions have been actioned, where appropriate, to prevent recurrence. Although no regulatory action has been taken by the ICO, we have enacted recommendations where appropriate including communications to Trust staff via e-mail broadcast and desktop screen 'banana skin' tiles. We will continue to monitor and assess information governance breaches. When weaknesses in systems or processes are identified there will be interventions undertaken. Low-level and near-miss events will be monitored and when there are common themes we will undertake Trust-wide communications to address these themes. We will continue to support information governance training via the national e-learning tool. All staff to undertake annual refresher training as a reminder of their information governance obligations.			

The Trust has a robust Information Governance function and framework that utilises subject matter expertise from Information Governance (IG), Information, Communication and Technology (ICT), networks, informatics, health records and systems administration. The Trust's Senior Information Risk Owner (SIRO) (Chief Financial Officer) and Caldicott Guardian (Medical Director) are members of this group. The group makes assurance reports to the Finance and Performance Committee, thereby maintaining a reporting line to the Board of Directors as required by regulation. It maintains effective links with the Trust's clinical teams by the escalation of incidents to the Trustwide Clinical Governance Group on a quarterly basis.

The group monitors IG breach incidents, maintaining oversight of level 2 SIRI breaches, as well as triggering appropriate responses to clusters or themes of low-level non-SIRI incidents.

2.9.7.2 Data security

The Trust recognises that our approach to information security requires, as described in the seventh Data Protection Principle, both a technical and organisational approach.

The Trust has a highly developed and mature approach to information governance, which includes high compliance with staff IG training and a comprehensive suite of IG-related procedural documents, giving instruction and regulation to our staff. The Trust deploys the mandatory public sector safeguards recommended by the HM Government Cabinet Office "Data Handling Procedures in Government"; including the operation of secure network storage, port control and the provision of encrypted digital media, and the encryption of high-risk portable computing resources.

The Trust continues to use NHS mail, facilitating secure digital communications with other NHS partners and the wider public sector via the Government Secure Intranet (GSi).

Senior managers in ICT receive the NHS Digital "CareCERT" broadcasts, to maintain an awareness of current information security threats so that timely and appropriate action can be taken where necessary. This has been further enhanced with the establishment of a CareCERT action tracking solution, with all CareCERT-reported threats recorded, assessed for exposure and potential impact, with solutions tracked, implemented and reported monthly to the IG Group.

The Trust has rolled out the revised national NHS IG Training offering *Data Security Awareness Level 1*, which contains both refreshed content on IG in a healthcare context and entirely new content on the user aspects of information / cyber security.

We have a robust approach to business continuity (BC) / disaster recovery (DR) within ICT, with senior management taking ownership of developing BC/DR plans for their services. Work is under way to align ICT BC/DR with clinical service system criticality. Review cycles of current plans are undertaken in response to any actual or near-miss BC/DR events.

The Trust made a self-assessment against the Information Governance Toolkit of 'satisfactory' / 'green' overall as at 31 March 2018, achieving Level 2 or higher for all IG requirements.

2.9.8 ANNUAL QUALITY REPORT

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercising the powers conferred on Monitor) has issued guidance to NHS foundation trust boards on the form and content of Annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The Director of Nursing and Professions is the executive director with the responsibility for the Quality Report. The Quality Committee enables the Trust to report directly to the Board on issues of quality governance and risks that may affect the service user's experience, outcome or safety.

To ensure the Quality Report presents a properly balanced picture of the Trust's performance over the year, the report goes to the Quality Committee which is chaired by a non-executive director with a lead on quality for assurance.

The performance information included in the Quality Report is in line with the performance information reported to the Executive Team, the Board of Directors and the Council of Governors through the following mechanisms:

- Performance reports to the Board of Directors, which set out performance against external requirements including NHS Improvement targets, the Single Oversight Framework and our contractual requirements with our main commissioners
- Assurance regarding maintaining CQC registration requirements is managed through the monthly CQC Project Group with assurances being made to the Quality Committee
- Performance reports to the Council of Governors
- The Executive Performance Overview Group seeks to supportively challenge performance within directorates.

There are systems and processes in place for the collection, recording, analysis and reporting of data which will ensure this is accurate, valid, reliable, timely, relevant and complete.

To manage the risk of there being incorrect data, the Trust has a Data Quality Policy which clearly identifies roles and responsibilities for the collection and input of service user information into patient records' systems. The Data Quality Team deals with erroneous entries and there are systems and processes in place to alert relevant managers of any issues in order to ensure that data presented in the Quality Report is both accurate and reliable. A data quality warehouse is used to ensure that data quality issues are dealt with proactively and quickly to maintain data integrity.

2.9.9 REVIEW OF EFFECTIVENESS

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit, and the executive managers and clinical leads within the Leeds and York Partnership NHS Foundation Trust who have responsibility for the development and

maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, the Quality Committee, the Finance and Performance Committee, and the Mental Health Act Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

I have drawn on the content of the performance information available to me. My review is also informed by comments made by the external auditors in their opinion; the Head of Internal Audit Opinion other audit reports. I have been advised on the effectiveness of the systems of internal controls by: the Board of Directors; the Audit Committee; the Quality Committee; the Finance and Performance Committee; the Mental Health Legislation Committee; the Board Assurance Framework; and internal audit reports. I have also been advised by leadership from the executive directors with regard to risk reporting (clinical and non-clinical), implementing learning, and plans to address weaknesses and ensure continuous improvement of the systems in place.

2.9.10 CONCLUSION

In summary, the Trust has a sound system of internal control in place and there are no significant control issues. The systems of internal control are designed to ensure delivery of the Trust's goals and strategic objectives and to manage and minimise exposure to risks and that no significant internal control issues have been identified.

I am satisfied that the process for identifying and managing risks is robust and dynamic as evidenced above. I am also satisfied that the Trust is doing all it can to mitigate the risks that have been identified and has in place a sufficient system of internal control to manage the strategic and other organisational risks.

Dr Sara Munro
Chief Executive

Date: 24 May 2018

SECTION 3 – THE BOARD OF DIRECTORS (further information)

3.1 INTRODUCTION

The Board of Directors is the body legally responsible for the day-to-day management of the organisation and is accountable for the operational delivery of services, targets and performance, as well as the definition and implementation of our strategy. It has a duty to ensure the provision of safe and effective services for our service users. It does this by having in place effective governance structures and by:

- Establishing and upholding our values and culture
- Setting the strategic direction
- Ensuring we provide high quality, safe, effective and service user focused services
- Promoting effective dialogue with our local communities and partners
- Monitoring performance against our objectives, targets, measures and standards
- Providing effective financial stewardship
- Ensuring high standards of governance are applied across the organisation.

The Chair of the Trust is responsible for ensuring that the Board of Directors focuses on the strategic development of our organisation and that robust governance and accountability arrangements are in place. The Chair of the Trust chairs both the Board of Directors and the Council of Governors and ensures there is effective communication between the two bodies and that where necessary the views of the governors are taken into account by the Board.

Whilst the executive directors individually are accountable to the Chief Executive for the day-to-day operational management of the organisation they, along with the non-executive directors, are part of the unitary Board. They all share corporate responsibility and liability for ensuring that our Trust operates safely, effectively and economically They do this by making objective decisions in the best interests of the Trust. The non-executive directors will assure themselves of performance by holding the executive directors to account for the achievement of the agreed goals, objectives, targets and measures.

The Board sets out the Trust's vision, values and standards of conduct, whilst ensuring that its obligations to members and the public are understood, clearly communicated and met. This is achieved by ensuring that the Board is made up of individuals who have the appropriate balance of skills, experience, independence and knowledge to enable the Board to discharge its duties and responsibilities effectively. The Board provides entrepreneurial leadership in a transparent manner and supports Trust staff in accordance with the Trust's values and accepted standards of behaviour in public life, including the Nolan Principles of:

- Selflessness
- Integrity
- Objectivity
- Accountability
- Openness
- Honesty
- Leadership.

The Board will reserve certain matters to itself and will delegate others to specific committees and executive directors. Details of this are set out in a document called *Reservation of Powers to the Board of Directors and Council of Governors and Schedule of Decisions/Duties Delegated by the Board of Directors*. Copies of this document are available on our website www.leedsandyorkpft.nhs.uk .

3.2 COMPOSITION OF THE BOARD OF DIRECTORS

3.2.1 Non-executive directors

Our non-executive director (NED) team is made up of seven non-executive directors including a non-executive Chair. During 2017/18 there were two new NED appointments: Helen Grantham who was appointed with effect from 15 November 2017, and Martin Wright who was appointed with effect from 20 January 2018. In the previous year (2016/17) the Council of Governors appointed our new Chair, Prof Sue Proctor, who commenced her appointment on 1 April 2017. More detailed information about our non-executive directors is set out in the Remuneration Report in Part A section 2.4 of this Annual Report.

3.2.2 Executive directors

The executive director team is made up of six executives, including the Chief Executive. The team is made up as follows:

Chief Executive	Medical Director
Chief Financial Officer and Deputy Chief Executive	Director of Nursing and Professions
Chief Operating Officer	Director of Workforce Development

There have been a number of changes in the executive director team during 2017/18.

In 2016/17, Joanna Forster Adams was appointed through a full competitive interview process and she took up her position with effect from 3 July 2017. With this substantive appointment, Lynn Parkinson, who had been the Interim Chief Operating Officer, returned to her substantive post as Deputy Chief Operating Officer.

On 24 September 2017, Anthony Deery went on secondment to take up a joint role with NHS England and NHS Improvement. With effect from 25 September 2017, Paul Lumsdon was appointed as the Interim Director of Nursing, Professions and Quality until 28 February 2018. Cathy Woffendin then took up her appointment as the substantive Director of Nursing and Professions with effect from 1 March 2018.

3.2.3 Members of the Board of Directors

Information about who our members of our Board of Directors were on 31 March 2018 can be found in Part A section 2.1.1 of this Annual Report.

3.3 PROFILE OF MEMBERS OF THE BOARD OF DIRECTORS

Prof Sue Proctor, Chair of the Trust

Prof Sue Proctor is the Chair of the Trust Board. As Chair, along with the non-executive directors, her role is to hold the Chief Executive and her executive team to account for the delivery of the organisation's strategic aims and objectives. Sue chairs the Board of Directors, the Council of Governors, the Remuneration Committee, the Nominations Committee and the governors' Appointments and Remuneration Committee.

Sue has expertise in leadership development, corporate and clinical governance, safeguarding, strategic planning and delivery. She has a passion for improving services for service users and carers by working in partnership with them.

Sue has over 30 years of experience in health care; qualifying as a nurse in 1987 and a midwife in 1990. She has extensive leadership experience in the NHS, including seven years as an executive director, and four years as a non-executive director. From 2010 to 2013 she was Chief Officer at the Diocese of Ripon and Leeds.

She currently runs a management consultancy working with charity and faith-based organisations. She has strong links with higher education as a former member of the University of Leeds Council and a Visiting Professor at Leeds Beckett University. Currently, she is Chair of the Strategic Safeguarding Group for the Diocese of York, and a lay member of the Veterinary Nursing Council at the Royal College of Veterinary Surgeons.

In the last few years, she has led two extensive and complicated investigations into allegations of historical sexual abuse. From 2013 to 2014, she chaired the independent investigation into matters relating to Jimmy Savile at Leeds Teaching Hospitals NHS Trust and then led the national NHS Savile Legacy Unit overseeing 16 subsequent Savile-related NHS investigations. In 2016, she led an investigation into abuse at a former children's home in Kent.

From August 2013 to March 2017 Sue was Vice Chair of Harrogate and District NHS Foundation Trust; she was a member of their Audit Committee and the Quality Committee, as well as being the non-executive lead for research and development within the Trust.

Prof John Baker, Non-executive Director (Chair of the Quality Committee)

Prof Baker's role on the Board is to hold the Chief Executive and her executive team to account for the delivery of the organisation's strategic aims and objectives. He is also the Chair of the Quality Committee.

By holding the executive directors to account he is able to be assured that services are provided in the most effective and efficient way. As Chair of the Quality Committee he can be assured that we provide high quality services. He can also be assured that we make the best use of research and evidence based practice to benefit the development of our services.

John has a passion for ensuring that quality is at the heart of what we do and for ensuring that the voice of our service users and carers is heard and able to influence the way in which we provide our services.

John is a registered mental health nurse and nurse teacher with the Nursing, Midwifery Council with 20 years clinical and academic experience. He has a strong international reputation as a leading mental health nurse, researcher and clinical academic and is a Professor of Mental Health Nursing at the University of Leeds.

Helen Grantham, Non-executive Director

Helen's role on the Board is to provide support and challenge in ensuring that the Trust is well led and delivering on its aims and objectives now and into the future. She is a member of the Quality Committee and the Audit Committee.

She contributes to improving the experience of staff and service users and carers by having a particular focus on workforce related matters and the Trust's aim of being an 'Employer of Choice'. By having skilled and engaged employees demonstrating the values of the Trust in the work they do, then service users and carers should have improved experiences.

She brings 30 years of leadership experience, with the last 17 years having been in Local Government. Until October 2017, she was the Assistant Chief Executive at Wakefield Council with responsibility for HR, ICT, Communications, Customer Services, Policy and Performance.

She has recently become freelance as director / owner of Entwyne Ltd, providing HR and Organisational Development consultancy.

Margaret Sentamu, Non-executive Director

Margaret's role on the Board is to hold the Chief Executive and her executive team to account for the delivery of the organisation's strategic aims and objectives. She is a member of the Audit Committee and a member of the Mental Health Legislation Committee. She also actively carries out the role of Mental Health Act Manager.

By holding the executive directors to account Margaret is able to be assured that services are provided in the most effective and efficient way. As a member of the Audit Committee she can be assured that the Trust is well governed and that we have effective processes and procedures in place. As a member of the Mental Health Legislation Committee and a practising Mental Health Act Manager she can make sure that we correctly apply the mental health legislation and ensure that we correctly review the detention of service users who are either detained under the Mental Health Act or who have been placed on Community Treatment Orders (CTO), and discharge those service users who no longer meet the criteria to be detained or are subject to a Community Treatment Order.

Margaret's background is in recruitment and selection in the private, public and the third sectors. More recently she has focused on helping organisations to embed diversity practices in the workplace by challenging unconscious bias in the areas of recruitment, retention and people development.

Her portfolio career also includes regulating solicitors who breach the code of conduct for the Solicitors Regulatory Authority; and accountants, who are members of the Chartered Institute of Public Finance and Accountancy (CIPFA) who breach the by-laws. She has recently stepped down from the Advisory Board of the Bradford School of Management. Margaret is a trustee and patron of a number of charities in the areas of health, education and poverty and is keen to strengthen partnerships between the mental health sector and the third sector and help fight stigma and discrimination.

As a non-executive director of Traidcraft she helps that Board to think strategically about how to combat poverty through fair trade practices.

Sue White, Non-executive Director (Chair of the Mental Health Legislation Committee)

Sue's role on the Board is to hold the Chief Executive and her executive team to account for the delivery of the organisation's strategic aims and objectives. She is also the Chair of the Mental Health Legislation Committee and a member of the Finance and Performance Committee.

By holding the executive directors to account Sue is able to be assured that services are provided in the most effective and efficient way. As Chair of the Mental Health Legislation Committee she can be assured that we correctly apply the mental health legislation and correctly review the detention of service users who are either detained under the Mental Health Act or who have been placed on Community Treatment Orders (CTO), and that we discharge those service users who no longer meet the criteria to be detained or are subject to a Community Treatment Order. Sue has a passion for ensuring that the services our Trust provides are of a high quality and that service users are at the heart of everything we do.

Sue has recently retired as the Chief Executive and Company Secretary for Voluntary Action Sheffield (VAS) where she had responsibility for strategic and operational leadership and for the leadership and representation of the voluntary and community sector in the city. Before this she worked for Sheffield Teaching Hospitals NHS Trust as the Business Development and External Affairs Director and also worked for the Department of Health as Head of Social Enterprise Unit. Sue brings to the Board experience of working in the complex environment of health and social care and in building partnerships at local, regional, national and international level.

Martin Wright, Non-executive Director (Chair of the Audit Committee)

Martin's role as a non-executive director is to hold the Chief Executive and the executive team to account for the delivery of the organisation's strategic aims and objectives. He is the Chair of the Audit Committee and a member of the Finance and Performance Committee.

Part of his role is to make sure that services are being provided in the most effective and efficient way and as the Chair of the Audit Committee he ensures that the committee looks closely at the Trust's budgets and spending; making sure that the Trust is getting best value from every penny it spends and is using its resources wisely to offer the highest quality services possible.

He was the Deputy Chief Finance Officer for DLA Piper International, one of the largest global law firms, where he was responsible for all aspects of financial reporting and control, including treasury, taxation and financial planning. He managed an international team of finance staff which provided support for more than 4,000 lawyers operating in more than 30 countries around the world.

Steven Wrigley-Howe, Non-executive Director (Senior Independent Director) (Chair of the Finance and Performance Committee)

Steven's role on the Board is to hold the Chief Executive and the executive team to account on the delivery of the organisation's strategic aims and objectives. He is the chair of Finance and Performance Committee and a member of the Quality Committee.

He has also been appointed by the Board as the Senior Independent Director. This role means that he is available to members of the Trust and to governors in instances where they have concerns which have been raised through the usual channels of Chair, Chief Executive, Chief Financial Officer or Trust Board Secretary and these have failed to resolve the issue. He is also available where it would be inappropriate to use such channels.

By holding the executive directors to account Steven is able to be assured that services are provided in the most effective and efficient way. As Chair of the Finance and Performance Committee he is able to make sure that we are in a strong position to use the money we receive in the best way we can to benefit our service users and their carers, and that we take opportunities to build a sustainable organisation able to continue to provide high quality services. Steven also has personal experience of using mental health services, and caring for those who have used both mental health and learning disability services, and this experience helps inform the work he does.

He is a Director of the Dublin-based charity, The Rehab Group, which provides care, training and employment services to people with a wide range of disabilities. He was previously a Trustee of York Mind and worked with national Mind on a number of service user engagement projects.

He has 30 years' experience within healthcare in various management and executive roles, including ten years running a healthcare consultancy with both public sector and independent sector clients.

Dr Sara Munro, Chief Executive

Dr Sara Munro leads the team of executive directors who, along with the chair and the non-executive directors, make up our Board of Directors. The Board is responsible for setting the strategic direction for the organisation. Sara is also a senior leader within a wider group of chief executives and chief officers that come together to look at health and social care provision across Leeds and across West Yorkshire.

Sara contributes to improve the experience of service users and carers by ensuring we set the right objectives for our organisation which reflect the needs of our service users, carers and local communities. She will then make sure we provide the right support, including resources, for our staff to deliver the best possible mental health and learning disability services for the people we serve; that we monitor how well we are doing; and that we include service users, carers, communities and our staff in the decisions we make about our services.

Dr Munro was appointed to the post of Chief Executive on 5 September 2016. She started her career in the NHS as a student nurse and agency nursing assistant. She is a registered mental health nurse and her clinical work was spent in inpatient mental health settings and has worked across a range of NHS mental health providers in the North West of England.

Sara has completed a PhD looking at attitudes of acute mental health nurses and their impact on service users' experience of care. Prior to working at our Trust she was the Director of Quality and

Nursing / Deputy CEO in Cumbria. Nationally, she is also a board member of the Positive Practice Collaborative and actively contributes to the Time to Change programme looking at attitudes of professionals towards mental health.

Joanna Forster Adams, Chief Operating Officer

As Chief Operating Officer Joanna works with the Trust's managers and staff to lead and support all our care services. She focuses on developing and improving service delivery, often working alongside our health and social care partners. Joanna is also responsible for major service change and supporting people to make these changes positively, and is also responsible for making sure we can respond to an emergency or crisis situation and provide continuity for our service users and support for the wider public as needed.

Joanna contributes to improving the experience of service users and carers by reporting on what we're doing well and where we don't meet the standards of care, access or delivery which provides high quality care for our service users. She ensures that at a glance 'dashboard' is available to make the information easier to understand. She, and her team, will pay particular attention to the problems that directly affect service users and their carers and look for ways to improve the quality of what we do.

Joanna joined the Trust in July 2017. She was previously Executive Director of Operations for Mental Health and Community Services in the North West of England. She has worked in the NHS since 1984 and has experience of clinical and corporate services in hospitals, community and mental health organisations in the north east. She gained a Master's in Business Administration from Durham University and is a graduate of the NHS Leadership Academy Nye Bevan programme.

Her motivation is drawn from the passion and determination shown by staff, stakeholders, service users and carers to drive improvement in mental health care. During her 20 years as a senior NHS manager she has been keen to help staff be the best that they can be through personal and professional development.

Dawn Hanwell, Chief Financial Officer and Deputy Chief Executive

Dawn leads a number of departments which include finance and contracting, information management and technology (including mHabitat), estates and facilities and procurement (including the North of England Collaborative Procurement Partnership).

The functions she oversees make a significant contribution to the work of our Trust's frontline staff, in order to support them to focus on working directly with service users and carers. These functions contribute by:

- Looking after the finances and advising on what we can spend our resources on, including how to buy goods and services within the limits which we are set
- Dealing with our commissioners to get the best possible income settlement to provide the services we deliver
- Maintaining the estate to the best possible standard for delivering safe care and providing a good environment for staff
- Maintaining and continuously improving the technology, tools and infrastructure which support our work on a daily basis.

Dawn was appointed to this post on 1 August 2012, having previously worked at our Trust as the Deputy Director of Finance between 2003 and 2007. Her last role was as Director of Finance and Information at Barnsley Hospital NHS Foundation Trust. She started her career in the NHS as a financial management trainee many years ago and has worked across a number of NHS organisations, mainly on the provider side but also briefly in commissioning and at the Department of Health. She has a wide range of experience mostly in finance but more recently managing estate and information.

Her first degree is in Theology and Religious Studies and she qualified as an accountant with the Chartered Institute of Public Finance Accountancy (CIFFA) in 1990.

Dr Claire Kenwood, Medical Director

Dr Claire Kenwood is our Medical Director and is responsible for applying the best medical practice and the highest quality of care for our service users.

Claire studied medicine at Birmingham University and qualified in 1988. She began her career in mental health in 1989 and completed her training in a variety of placements and specialties in Birmingham and Southampton, becoming consultant in assertive outreach in 1999.

After a period of work in Trafford as a consultant in assertive outreach and rehabilitation she moved to Scotland and spent 10 years working in Livingston, initially as a consultant and then as Clinical Director. Here she developed an interest in clinical leadership, initially completing a post graduate certificate in front line leadership and management and becoming a member of the chartered institute of managers. After this she completed a master's degree in clinical leadership at Glasgow University and then a master's degree in advanced leadership practice with Edinburgh Napier and Harvard Executive Education. The focus of these studies was on clinical, quality and safety and in particular research interests in relationships and leadership required for good service user outcomes.

In 2014 Claire took up a post in Cumbria Partnership NHS Foundation Trust as Associate Medical Director for Quality, also clinically supporting and leading the development of a new inpatient rehabilitation service for men. During this time she was successful in becoming part of the first cohort of the Q initiative and also a non-executive director of the Quality Improvement Organisation AQuA.

On 1 March 2017 she joined the Trust as the Medical Director.

Susan Tyler, Director of Workforce Development

Susan leads a directorate which includes operational human resources, learning and organisational development, communications and staff engagement, diversity and inclusion and workforce systems, planning and information.

Our staff are our biggest asset and they have a huge impact on the care and experience people receive from us. Susan's directorate leads on the staff we employ, including:

- How we recruit them
- How we train and develop them
- How we ensure we are accessible and represent all our communities
- The values and behaviours we expect of staff
- How we communicate and engage with staff because engaged staff deliver better health care.

Susan was appointed to the post of Director of Workforce Development on 1 January 2012 and has previously worked for a number of trusts across West and South Yorkshire including as Deputy Director of HR at Mid Yorkshire Hospitals NHS Trust and HR Director at Barnsley NHS Foundation Trust.

During her career she has held a number of senior roles in training and organisational development. She has experience across all aspects of healthcare provision including acute, primary care and mental health and learning disabilities.

She has a master's degree in Human Resource Management and is a member of the Chartered Institute for Personnel Development (MCIPD). She holds the Institute of Leadership Management (ILM) level 5 in coaching and mentoring and is a trained health coach.

Cathy Woffendin, Director of Nursing and Professions

Cathy leads on the development of the professions within the Trust which covers Nursing, Allied Health Professionals and Psychology. Her particular focus is to ensure that quality is of a high standard across the organisation and she works closely with Claire Kenwood our Medical Director, to oversee the current quality and delivery of our services and shape these to best meet future needs. Cathy contributes to improving the experience of service users and carers in many ways but in particular by leading a team which works directly with service users to gather and share their insight and feedback about their experience whilst in our care. This feedback is a vital tool for us as it shows us where we're getting things right and where there is still work to be done to improve our services.

Cathy is a qualified nurse and has worked in a variety of organisations in the NHS and private sector for over 30 years. She did some further training and gained a degree in Public Health Nursing and then worked as a health visitor developing a child health and safeguarding specialism. She moved into management in 2005 and has undertaken further study at Master's level in Management and leadership

3.4 MEETINGS OF THE BOARD OF DIRECTORS

Our Board meets monthly with the exclusion of August, although in 2017/18 the Board did not need to meet in December. All meetings are held in public but items which are of a confidential nature (as defined by pre-determined criteria and in accordance with the Constitution) will be taken in a private session.

In 2017/18 the Board of Directors met on 11 occasions. The table below shows directors' attendance at those meetings. Attendance at Board meetings is also reported to the Council of Governors at each of its meetings.

Table 3A – Attendance at Board of Directors' meetings during 2017/18

Name	Meetings eligible to attend	27 April 2017	25 May 2017	29 June 2017	27 July 2017	28 September 2017	26 October 2017	30 November 2017	6 December 2017 (Extra Ordinary)	25 January 2018	22 February 2018	29 March 2018
Non-executive directors												
Prof Sue Proctor (Chair)	11	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
John Baker	11	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Helen Grantham	5							✓	-	✓	✓	✓
Margaret Sentamu	11	✓	-	✓	✓	✓	-	✓	✓	✓	✓	✓
Jacki Simpson	4	-	✓	✓	✓							
Julie Tankard	8	-	✓	-	✓	✓	-	-	-			
Sue White	11	✓	✓	✓	✓	✓	✓	✓	-	✓	✓	✓
Martin Wright	3									✓	✓	✓
Steven Wrigley-Howe	11	✓	✓	✓	✓	✓	✓	✓	✓	-	✓	✓
Executive directors												
Sara Munro	11	✓	✓	-	✓	✓	-	✓	✓	✓	✓	✓
Anthony Deery	5	✓	✓	-	✓	✓						
Joanna Forster Adams	8				✓	✓	✓	✓	✓	✓	✓	✓
Dawn Hanwell	11	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Claire Kenwood	11	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Name	Meetings eligible to attend	27 April 2017	25 May 2017	29 June 2017	27 July 2017	28 September 2017	26 October 2017	30 November 2017	6 December 2017 (Extra Ordinary)	25 January 2018	22 February 2018	29 March 2018
Paul Lumsdon	5					-	✓	✓	✓	✓	✓	
Lynn Parkinson	3	✓	✓	✓								
Susan Tyler	11	✓	✓	-	✓	✓	✓	✓	✓	✓	✓	✓
Cathy Woffendin	1											✓

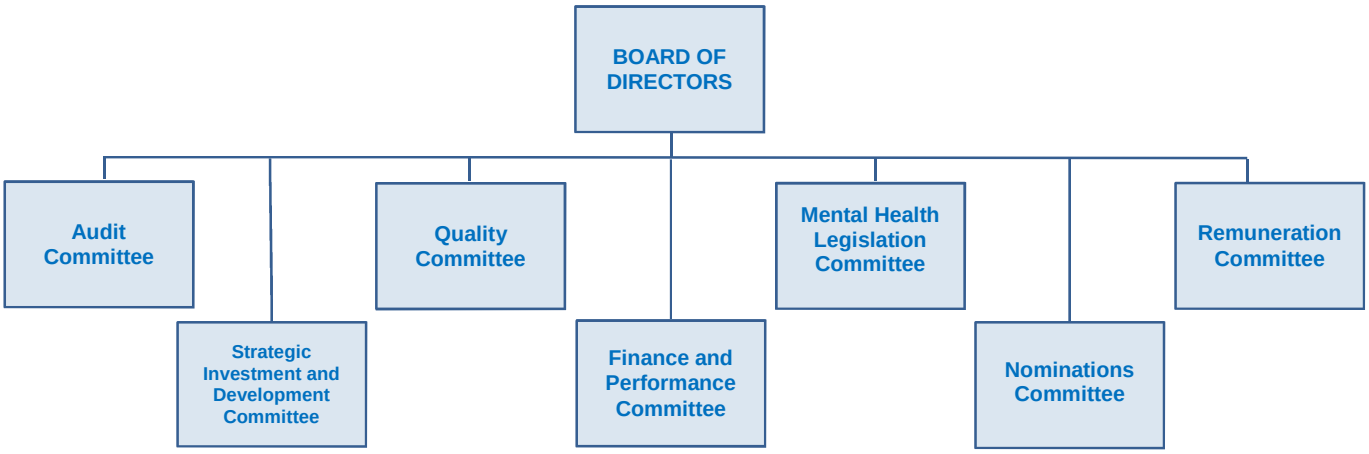
3.5 EVALUATION OF THE BOARD OF DIRECTORS

3.5.1 The Board of Directors and members of the Board

Details relating to the evaluation of the members of the Board of Directors can be found in Part A section 2.4.3.2 of this Annual Report.

3.5.2 Board sub-committees

The Board's sub-committee structure is made up of the: Audit Committee, Quality Committee, Finance and Performance Committee, Mental Health Legislation Committee, Strategic Investment and Development Committee, Remuneration Committee, and Nominations Committee. Each of these committees receives secretariat support from the Corporate Governance Team, except in the case of the Mental Health Legislation Committee which is supported by the Mental Health Legislation Team.



Evaluation of the Board sub-committees is carried out using an internal evaluation questionnaire. The outcome is reviewed by the committee and a report on any proposed changes that may be required is made to the Board of Directors by the chair of the committee. If required the Terms of Reference would be changed and ratified by the Board.

3.6 THE AUDIT COMMITTEE

The Audit Committee is the primary governance and assurance committee for the Trust. It is a formal sub-committee of the Board of Directors.

The Audit Committee seeks high-level assurance and provides an independent and objective review on the effectiveness of our governance (corporate and clinical) and risk management processes and it assures the Board of Directors in respect of internal controls. It receives assurance from executive directors and other areas of the organisation through reports, both regular and bespoke. It validates the information it receives through the work of Internal Audit and External Audit, again through reports and attendance by key personnel at its meetings to present papers on specific matters. Assurance is also brought to the committee through the knowledge that non-executive directors gain from other areas of their work, not least their own specialist areas of expertise, visiting services, and talking to staff and governors.

The Audit Committee has responsibility for ensuring that, should our auditors (KPMG) carry out any non-audit work, their independence is maintained. The committee will do this by reviewing and approving the scope of the work and the fees charged prior to the work being undertaken.

The substantive membership of the Audit Committee is made up at any one time of three non-executive directors. During 2017/18 the following members served on the committee as substantive members: Julie Tankard, who was the chair of the committee until 19 January 2018 (the role of chair of the Audit Committee was then taken on by Martin Wright with effect from 20 January 2018), Helen Grantham, Margaret Sentamu and Jacki Simpson. The other non-executive directors are invited to attend on an ad-hoc basis as and when they feel it is appropriate, with the Chair of the Trust and the Chief Executive being invited to attend the Audit Committee on an annual basis; in 2017/18 Prof Sue Proctor attended the meeting in April 2017 and Sara Munro attended the meeting in May 2017.

On 19 January 2018 Julie Tankard stepped down as a non-executive director for the Trust and as such chair of the Audit Committee. Martin Wright who was appointed as a non-executive director with effect from 20 January 2018 took over the chairing of the committee from that date. He attended his first meeting (in an observer capacity and as part of the handover process) on 19 January 2018 and chaired his first meeting on 17 April 2018. The committee wishes to extend its thanks to Mrs Tankard for the diligent way in which she chaired the meeting and her support to the work of the Trust more widely.

In regular attendance at committee meetings are the Chief Financial Officer, and the Head of Corporate Governance. There is also representation from our external auditors (PricewaterhouseCoopers LLP until 30 September 2017 and KPMG from 1 October 2017), and Audit Yorkshire which provides our internal audit and counter-fraud services.

The table below shows the number of Audit Committee meetings in 2017/18 and attendance by each non-executive director member.

Table 3B – Attendance at Audit Committee meetings in 2017/18

Name	24 April 2017	17 May 2017	17 July 2017	17 November 2017	19 January 2018
Substantive non-executive director members					
Julie Tankard (chair of the committee)	✓	✓	✓	✓	✓
Margaret Sentamu	✓	✓	✓	✓	✓
Jacki Simpson		-	✓		

During 2017/18 the Audit Committee fulfilled the role of the primary governance and assurance committee and carried out its role primarily through:

- The approval of the work plans (annual and strategic) for internal audit and counter fraud
- The approval of the work plan for the annual audit of the Annual Accounts, the Annual Report and the Quality Report
- Regular progress reports and annual reports from internal audit and counter fraud
- Regular updates from the external auditors on current sector developments and their audit findings
- ISA 260 report on the outcome of the annual audit of annual accounts
- Assessing the effectiveness of external and internal audit by reviewing periodic reports from the auditors and monitoring the pre-agreed key performance indicators
- Following a robust procurement process, making a recommendation to the Council of Governors to appoint KPMG as the Trust's external auditors with effect from 1 October 2017.

In 2017/18 the committee reviewed the Annual Report, Annual Accounts, the Quality Report, the Annual Governance Statement and the Head of Internal Audit Statement for 2016/17. It was assured in relation to each of these documents and recommended to the Board that they should be adopted.

A separate annual report for the Audit Committee is produced and submitted to the Board of Directors for assurance and is also submitted to the Council of Governors for information. This can be found on our website at www.leedsandyorkpft.nhs.uk.

Further information about the sufficiency of our internal control processes can be found in the Annual Governance Statement in Part A section 2.9 of this Annual Report.

SECTION 4 – THE COUNCIL OF GOVERNORS

4.1 COMPOSITION OF THE COUNCIL OF GOVERNORS

The Council of Governors is the body that gives the public a voice in helping to shape and influence the future of mental health and learning disability services provided by our Trust. It is made up of people who have been elected from and by our membership and who are representative of our constituencies. It also includes people appointed from a range of partner organisations. The Council of Governors is chaired by the Chair of the Trust, who ensures a link between the Council and the Board of Directors; the Deputy Chair of the Trust is also the Deputy Chair of the Council of Governors.

NHS Improvement requires each foundation trust to have a Lead Governor. Steve Howarth, who is an elected governor for the constituency of Leeds Public, was elected as Lead Governor by the Council on the 14 February 2017 for a period of one-year. At the Council meeting on the 14 November 2017, the Council agreed to change the period of appointment for the Lead Governor to two years to allow individuals undertaking this role to develop into it and provide greater continuity. The Council also agreed that Steve Howarth's appointment would be for a two-year period, and this now finishes in February 2019. Steve, as our Lead Governor, works with Steven Wrigley-Howe, our Senior Independent Director, to review the feedback received on the Chair of the Trust that is then used to form part of the Chair's appraisal.

During the 2017/18 there was no change to the composition of seats within our Council of Governors. The composition ensures the Council is representative of our members and the public. Table 4A shows the composition of seats within our Council of Governors.

Table 4A – Composition of our Council of Governors

	Constituency name	Number of seats
ELECTED	Public: Leeds	6
	Public: York and North Yorkshire	1
	Public: Rest of England and Wales	1
	Service User: Leeds	4
	Service User: York and North Yorkshire	1
	Carer: Leeds	3
	Carer: York and North Yorkshire	1
	Service user and Carer: Rest of the UK	1
	Clinical Staff: Leeds and York & North Yorkshire	4
	Non-clinical Staff: Leeds and York & North Yorkshire	2
APPOINTED	Equitix Ltd (our PFI partner)	1
	Volition (third sector mental health network)	1
	Tenfold (third sector learning disabilities network)	1
	York Council for Voluntary Services	1
	Leeds City Council	1
	City of York Council	1
	TOTAL	**30**

Governors are either elected or appointed to seats on the Council of Governors for a period of up to three years. Elected governors consist of public, service user, carer, and staff (clinical and non-clinical) governors. Appointed governors are nominated individuals from partner organisations. Elected governors can stand to be re-elected for three terms of office holding a seat for up to a maximum of nine-years. Elections are carried out in accordance with the election rules in Annex 5 of our Constitution. Further details about the elections we have held during 2017/18 can be found below in section 4.2.1.

Appointed governors can also be on our Council for a maximum of nine years. This period is made up of three terms each of up to three years.

Tables 4B and 4C list those governors that have been members on the Council of Governors during 2017/18.

Table 4B – Elected governors

Name	Constituency	Maximum term of office elected for	Date appointed from	Date term of office ends / ended	Number of terms served
Marc Pierre Anderson **	Service User: Leeds	3 years	25.09.17	24.09.20	1st
Andrew Bright *	Carer: Leeds	3 years	22.08.16	17.12.17	1st
Evrett Buckle *	Public: Leeds	3 years	22.08.16	16.05.17	1st
Brian Caldwell-White *	Public: Leeds	3 years	22.08.16	16.05.17	1st
Sarah Chilvers	Staff: Non-clinical	3 years	21.03.17	20.03.20	1st
Les France	Public: Leeds	3 years	22.08.16	21.08.19	1st
Gill Galea **	Staff: Clinical	3 years	25.09.17	24.09.20	1st
Anita Garvey	Public: Leeds	3 years	22.08.16	26.03.18	1st
Jo Goode	Staff: Clinical	3 years	21.03.17	20.03.20	1st
Ruth Grant *	Staff: Non-clinical	3 years	29.04.15	01.12.17	1st
Christopher Hobbs **	Carer: Leeds	3 years	25.09.17	24.09.20	1st
Steve Howarth	Public: Leeds	3 years	22.08.16	21.08.19	2nd
Andrew Johnson	Staff: Clinical	3 years	21.03.17	20.03.20	2nd
Kirsty Lee **	Public: Leeds	3 years	25.09.17	24.09.20	1st
Ellie Palmer	Service User: Rest of UK	3 years	21.03.17	20.03.20	1st
Alan Proctor	Carer: Leeds	3 years	22.08.16	21.08.19	2nd
Julia Raven	Carer: York and North Yorkshire	3 years	29.04.15	28.04.18	2nd
Sally Rawcliffe-Foo **	Staff: Clinical	3 years	25.09.17	24.09.20	1st
Jo Sharpe *	Public: York and North Yorkshire	3 years	29.04.15	05.02.18	2nd
Ann Shuter	Service User: Leeds	3 years	29.04.15	28.04.18	2nd
Niccola Swan	Public: Rest of England and Wales	3 years	22.08.16	21.08.19	2nd
Peter Webster	Public Leeds	3 years	22.08.16	21.08.19	1st
Claire Woodham	Service User: Leeds	3 years	22.08.16	09.08.17	2nd

* Indicates those governors who stepped down early during 2017/18, before the end of their term of office
** Indicates those governors who were newly elected or re-elected part-way through 2017/18

Table 4C – Appointed governors

Name	Constituency	Maximum term of office elected for	Date appointed from	Date term of office ends / ended	Number of Terms served
Sarah Armstrong	York Council for Voluntary Services	3 years	17.10.17	16.10.20	1st
Councillor Jenny Brooks	City of York Council	3 years	23.08.17	22.08.20	1st
Councillor Neil Dawson	Leeds City Council	3 years	15.02.17	14.02.20	1st
Helen Kemp	Volition	3 years	08.11.17	07.11.20	1st
Carol-Ann Reed *	Tenfold	3 years	02.04.15	24.04.17	1st

* Indicates those governors who stepped down early during 2017/18, before the end of their term of office

4.2 CHANGES TO THE COUNCIL OF GOVERNORS

During 2017/18 there were a number of changes to the individuals holding the position of governor on our Council of Governors. The Board of Directors would like to thank all those who either stepped down early from office or came to the end of the term of office and note the valuable contribution they made to the work of the Council. These are: Andrew Bright; Evrett Buckle; Brian Caldwell-White; Ruth Grant; Jo Sharpe; Carol-Ann Reed and Claire Woodham.

4.2.1 Elected governors

Elections are carried out in accordance with the election rules as set out in Annex 5 of the Trust's Constitution (elected governors are in the constituencies set out in Table 4A). To be eligible to stand for election you must be a member of our Trust. Where a vacancy then occurs in a constituency and the Trust agrees to hold an election, members in that constituency are invited to nominate themselves, and where there are more people standing for election than there are seats available it will be necessary to hold a ballot which is held on a first-past-the-post system of voting. In 2017/18 we held two rounds of elections one in autumn 2017 and the second in spring 2018. The results of the election held in spring 2018 will be presented in the 2018/19 Annual Report and Accounts because that election closed on the 30 April 2018.

4.2.1.1 Elections held in autumn 2017 (concluding on 25 September 2017)

During autumn 2017 an election was held to the Council of Governors. This was due to there being a number of vacant seats already on the Council caused either by governors stepping down early or because the seats had been vacant for some time. The following seats were included in the election:

Table 4D – Seats included in the autumn 2017 election

Constituency	Name of constituency	Number of seats included in the election
Public	Leeds	2
Carer	Leeds	1
Service User	Leeds	2
	York and North Yorkshire	1
Staff Clinical	Leeds and York and North Yorkshire	2

This round of elections commenced 8 September and concluded on 25 September 2017. We were successful in filling seats as follows:

Table 4E – Elected unopposed

Name	Constituency elected to:
Marc Pierre Anderson	Service User: Leeds
Gill Galea	Staff: Clinical
Christopher Hobbs	Carer: Leeds
Kirsty Lee	Public: Leeds
Sally Rawcliffe-Foo	Staff: Clinical

We did not need to hold a ballot as all the governors were elected unopposed. At the end of the election we still had vacancies in the Public Leeds (1 seat); Service User Leeds (1 seat) and Service User York and North Yorkshire (1 seat) constituencies, which went into the next round of elections.

4.2.1.1 Elections held in spring 2018

Although this round of elections concluded in 2018/19 and the outcome will be reported in the next annual report below are the seats included in the election that commenced on the 1 March 2018.

Table 4F – Seats included in the spring 2018 election

Constituency	Name of constituency	Number of seats included in the election
Public	Leeds	1
Public	York and North Yorkshire	1
Carer	Leeds	1
Carer	York and North Yorkshire	1
Service User	Leeds	3
	York and North Yorkshire	1
Staff Non-Clinical	Leeds and York and North Yorkshire	1

4.2.2 Appointed governors

Appointed governors are nominated by those organisations we have identified as our partner organisations, for the purpose of the Council of Governors, and are set out in table 4A.

During 2017/18 there were four changes to our appointed governors. Carol-Ann Reed (Tenfold) stepped down during her first term of office. Sarah Armstrong (York Council for Voluntary Services); Councillor Jenny Brooks (City of York Council); and Helen Kemp (Volition) all commenced their first term of office as appointed governors on the Council of Governors.

The Board of Directors would like to thank all the appointed governors it has worked with through the year for all their hard work, supporting the development of the services we provide, and we would like to welcome those newly appointed to our Council.

4.3 MEETINGS OF THE COUNCIL OF GOVERNORS

During 2017/18 the Council of Governors had six business meetings. All general Council meetings are held in public, although items which are of a confidential nature (as defined by pre-determined criteria and in accordance with the Constitution) will be taken in a private session. The table below shows attendance at those six meetings.

Notice of public Council of Governors' meetings along with the agenda and papers are published on our website www.leedsandyorkpft.nhs.uk.

The governors also hold an Annual Members' Meeting. This was held in September 2017. This is a public meeting and members are encouraged to attend to hear more about the work of the Trust and the Council of Governors. Table 4G shows those governors who attended the Annual Members' Meeting.

The table below details the number of meetings attended by each governor during 2017/18. This is shown out of a maximum of six meetings. If a governor has either resigned from, or joined the Council of Governors part-way through the financial year, the number of meetings they were eligible to attend has been amended to reflect this (those meeting dates which have been blanked out in the table indicate that a governor was not eligible to attend to the meeting).

Table 4G – Number of meetings attended by each governor

			COUNCIL BUSINESS MEETINGS ATTENDED						ATTENDANCE AT THE ANNUAL MEMBERS MEETING
Name	**Appointed (A) or elected (E)**	**Number of business meetings eligible to attend**	**16 May 2017**	**18 July 2017**	**5 September 2017 (private extraordinary meeting)**	**14 November 2017**	**6 December 2017 (private extraordinary meeting)**	**14 February 2018**	**19 September 2017**
Marc Pierre Anderson **	E	3				✓	-	-	
Sarah Armstrong **	A	3				-	-	✓	
Councillor Jenny Brooks **	A	4			-	✓	-	✓	-
Andrew Bright *	E	5	✓	✓	-	-	-		-
Evrett Buckle *	E	1	-						
Brian Caldwell-White *	E	1	-						
Sarah Chilvers	E	6	-	✓	✓	✓	✓	✓	✓
Councillor Neil Dawson	A	6	-	✓	✓	-	-	-	✓
Les France	E	6	✓	✓	-	✓	✓	✓	✓
Gillian Gallea **	E	3				✓	-	✓	
Anita Garvey	E	6	-	-	-	✓	✓	-	-
Jo Goode	E	6	✓	✓	✓	✓	✓	-	-
Ruth Grant *	E	5	✓	✓	-	✓	-		✓
Christopher Hobbs **	E	3				-	-	-	
Steve Howarth	E	6	✓	✓	✓	✓	-	-	✓
Andrew Johnson	E	6	-	✓	✓	-	-	-	✓
Helen Kemp **	A	3				-	-	✓	
Kirsty Lee **	E	3				✓	-	✓	
Ellie Palmer	E	6	✓	✓	-	-	-	✓	✓
Alan Proctor	E	6	-	-	-	-	-	-	-
Julia Raven	E	6	-	✓	✓	✓	✓	✓	✓
Carol-Ann Reed *	A	1	-						
Sally Rawcliffe-Foo **	E	3				✓	✓	-	

			COUNCIL BUSINESS MEETINGS ATTENDED						ATTENDANCE AT THE ANNUAL MEMBERS MEETING
Name	**Appointed (A) or elected (E)**	**Number of business meetings eligible to attend**	**16 May 2017**	**18 July 2017**	**5 September 2017 (private extraordinary meeting)**	**14 November 2017**	**6 December 2017 (private extraordinary meeting)**	**14 February 2018**	**19 September 2017**
Jo Sharpe *	E	5	-	✓	✓	-	-		✓
Ann Shuter	E	6	✓	✓	-	-	-	✓	✓
Niccola Swan	E	6	✓	✓	✓	✓	-	✓	-
Peter Webster	E	6	✓	✓	✓	✓	✓	✓	✓
Claire Woodham *	E	2	✓	-					

* Indicates those governors who stepped down during 2017/18, before the end of their term of office and as such may not have been eligible to attend all meetings (any meetings not eligible to attend are shaded out)

** Indicates those governors who were newly elected or appointed during 2017/18 and as such may not have been eligible to attend all meetings (any meetings not eligible to attend are shaded out)

4.4 DUTIES OF THE COUNCIL OF GOVERNORS

The overarching role of the Council of Governors is to make our Trust publically accountable for the services it provides. It does this by representing the interests of members as a whole and those of the public. It informs our forward plans, and holds the non-executive directors (NEDs) to account, individually and collectively, for the performance of the Board. Governors are not directors and the duty of holding the NEDs to account does not mean governors are responsible for the decisions taken by the Board of Directors (members of the Board of Directors (both executive and non-executive directors collectively) share corporate responsibility and liability for those decisions).

Further information about the work of the Board of Directors can be found in Part A section 3 of this Annual Report.

In addition there are a number of other key statutory tasks the Council of Governors must also carry out. These include:

- Appointing (and if necessary removing) the Chair of the Trust and non-executive directors
- Approving the appointment of the Chief Executive
- Appointing (and if necessary removing) the external auditor
- Receiving the Annual Report and Accounts, and the auditor's report on these
- Approving amendments to the constitution
- Taking decisions on significant transactions and also on any changes to non-NHS income.

If during the course of the Board of Directors and the Council of Governors carrying out their respective duties, it becomes apparent that there is a dispute between the Council and the Board there is a formal dispute resolution process which is set out in the Constitution at Annex 7 paragraph 10.

To help governors carry out their role, the Board of Directors also has a number of statutory duties placed on it including: sending a copy of the agenda of Board meetings to governors before each meeting and copies of minutes of meetings as soon as practicable after the meeting; and ensuring that governors have the skills and knowledge they require to undertake their role.

4.5 WORKING TOGETHER

The work of the Board of Directors and of the Council of Governors is closely aligned. The Chair of the Trust, supported by the Head of Corporate Governance, provides a formal link between the two bodies and it is the Chair's responsibility to ensure an appropriate flow of information.

The Council of Governors has a primary relationship with the non-executive directors (NEDs) who are encouraged wherever possible to attend Council meetings to get to know the governors better and to hear first-hand their views and those of members. One way in which this is further supported is through the annual Board to Council meeting. This private meeting includes a number of the Trust's key strategic areas of focus on the agenda. This meeting further enhances the relationship between the Council and the NEDs and provides an opportunity for the governors to work more closely with NEDs and other members of the Board. Governors are also invited to a number of the Board sub-committee meetings and are encouraged to attend at least one public Board of Directors' meeting each year. This provides further opportunity for the governors to witness the NEDs holding the executive directors to account for the performance of the Trust.

The following table shows those Council meetings that were attended by non-executive directors.

Table 4H – Attendance by non-executive directors at Council of Governors' meetings

Name	16 May 2017	18 July 2017	5 September 2017 (private meeting)	14 November 2017	6 December 2017 (private meeting)	14 February 2018
Non-executive directors						
Prof Sue Proctor	✓	✓	✓	✓	✓	✓
Prof John Baker	✓	✓	-	-	-	-
Helen Grantham					-	✓
Jacki Simpson	-	✓				
Margaret Sentamu	✓	✓	-	✓	-	✓
Julie Tankard	✓	✓	-	-	-	
Sue White	✓	✓	-	✓	-	✓
Martin Wright						-
Steven Wrigley-Howe	✓	-	-	-	-	-

4.6 SUB-COMMITTEES OF THE COUNCIL OF GOVERNORS

The Council of Governors may not delegate any of its responsibilities; however, it can choose to carry out its duties either through individual governors or through groups and committees. In light of this, the Council of Governors has formed two formal sub-committees to focus on specific areas of work. These committees are the Appointments and Remuneration Committee (a committee required in statute) and the Strategy Committee. Both of these committees report formally to the Council of Governors.

- **The Appointments and Remuneration Committee** – this committee reviews and makes recommendations to the Council of Governors regarding the appointments process for vacant posts within the non-executive director team, and also sets the level of remuneration for NEDs. Further information about the work of this committee during 2017/18 can be found in the Remuneration Report in Part A section 2.4 of this Annual Report.

- **The Strategy Committee** – this committee oversees the development of the business priorities; supports and oversees the delivery of the strategy and Operational Plan; and supports the process to refresh our strategy. During 2017/18 this Committee did not meet as governors contributed to the Strategy at the Board to Council meeting on the 5 September 2017. In the light of these changes the role of this committee is under review.

4.7 THE REGISTER OF GOVERNORS' INTERESTS

Under the provisions of the Constitution and as described in the provider license, we are required to have a register of interests to formally record declarations of interests of members of the Council of Governors. The register will include details of all directorships and other relevant material interests which have been declared. It also asks governors to declare that they are of sound character and background to hold a position in public office.

On appointment, members of the Council of Governors must declare any interests, which might place, or be seen to place them in a potential conflict of interest between their personal or private interest and those arising from their membership of the Council of Governors. Members of the Council of Governors are also required to declare any conflict or pecuniary interests that arise in the course of conducting

business at each meeting. Each year governors will complete a new declaration of interest form to ensure the most up-to-date position is declared. These annual declarations are also reported to the Council of Governors.

The Register of Interests is maintained by the Head of Corporate Governance and is available for inspection by members of the public on request. The Head of Corporate Governance can be contacted by telephone on 0113 8555930 or by email at chill29@nhs.net.

SECTION 5 – MEMBERSHIP

5.1 OUR CONSTITUENCIES AND ELIGIBILITY TO JOIN

As at 31 March 2018 the membership was 15,664. This has been steadily maintained throughout the year. The tables below illustrate the breakdown, by constituency, of the total number of members.

We have three membership constituencies: public; service user and carer; and staff. A breakdown of these is shown at table 5A.

There are three public constituencies: Leeds; York and North Yorkshire and Rest of England and Wales. These constituencies are made up of a number of local government electoral areas. This is in accordance with the NHS Act 2006. If a person wants to join a public constituency the relevant one will be determined by the address at which they live.

The Service User and Carer Constituency is divided into five constituencies for the geographical areas of: Leeds; York and North Yorkshire and the rest of England and Wales. Again these constituencies follow the local government electoral boundaries. Anyone who has used our services in the last 10 years or cares for someone who has used our services can join the Service User and Carer Constituency. An individual's home address will determine which constituency they join.

The Staff Constituency is divided into two categories: Staff: Clinical and Staff: Non-clinical. Any individual who is employed by the Trust under a contract of employment will automatically become a member unless they opt out. In addition to those individuals directly employed by the Trust, people who exercise a function for the Trust may also choose to be a member of the Staff Constituency. Whether a person joins the clinical or the non-clinical class will be determined by national occupation codes.

Table 5A – Membership constituencies

Public constituency	Service User and Carer constituency	Staff constituency
Public: Leeds Public: York and North Yorkshire Public: Rest of England and Wales	Service User: Leeds Service User: York and North Yorkshire Carer: Leeds Carer: York and North Yorkshire Service User and Carer: Rest of UK	Clinical Staff: Leeds and York & North Yorkshire Non-clinical Staff: Leeds and York & North Yorkshire

5.2 NUMBER OF MEMBERS

Table 5B – Total membership by constituency as at 31 March 2018

Public constituency	Number of members
Public: Leeds	8391
Public: York and North Yorkshire	1604
Public: Rest of England and Wales	1918
Total public members (including 35 members outside England and Wales)	**11948**

Service User and Carer constituency	Number of members
Service user: Leeds	572
Service user: York and North Yorkshire	95
Carer: Leeds	348
Carer: York and North Yorkshire	45
Service User and Carer: Rest of UK	107
Total service user and carer members	**1167**

Staff constituency	Number of members
Clinical staff: Leeds and York & North Yorkshire	1924
Non-clinical staff: Leeds and York & North Yorkshire	615
Total staff members (including 10 unspecified)	**2549**

Membership has maintained steady at 15,664 as at 31 March 2018. These tables illustrate the breakdown, by constituency, of the total number of members.

5.3 DEVELOPING A REPRESENTATIVE MEMBERSHIP

Members of the public, staff, service users, their families and carers can join our Trust as a member. We are responsible for ensuring that our membership is representative of the people that the Trust could provide services to. The profile of the current membership in terms of ethnicity, gender and age continues to be broadly in line with that of the respective constituencies, with no significant deficits.

During August 2017 a review of membership was undertaken by the Trust. Results from the review confirmed that membership numbers remained high and representative. It was felt that further work should be undertaken to develop meaningful engagement with members whilst maintaining total number of members. Work has taken place to review what meaningful engagement could look like for our members. It was decided the basis of this would include:

- Improving member engagement
- Communicating better with members
- Maintaining a representative membership.

Work has also been underway to create a clear branding for membership that is consistent with the Trust's brand and its wider strategy. The Trust has reached a strong solid membership number; now the focus will be on developing a programme of engagement for members whilst adhering to the Trust values.

We are undertaking developmental work in partnership with the database providers to identify areas within the constituencies that could be developed to further increase representation. This work will entail analysing the Intelligent Membership Strategy that the database produces that shows demographics across the Leeds, York and North Yorkshire areas.

5.4 MEMBERSHIP RECRUITMENT AND ENGAGEMENT

We value the contribution of our membership and focus will be on qualitative rather than quantitative membership levels and engagement. At their November 2017 meeting, the Council of Governors supported planned development work of the membership database alongside the creation of an ongoing engagement programme. Work to develop these areas of work in on-going and the governors recognised the importance of work needing to be done within each of the two areas.

A focused approach to membership engagement and recruitment will be supported by the development of the membership database. This will allow for focused recruitment and engagement campaigns to maintain a representative membership. Engagement with members will be enhanced through improved communication tools using the database, and a structured membership engagement plan that will be supported by the Trust's Communications Team.

Initial findings suggest that development of membership engagement would focus on the following four areas:

1) Stratifying the level of member involvement to offer them a way to engage with the Trust how they choose
2) Increasing opportunities for member engagement
3) Providing opportunities for staff to become more actively engaged as members
4) Providing a more focused role for governors with members.

5.5 THE MEMBERSHIP OFFICE

The Membership Office is the initial point of contact for members to speak to someone within our Trust or with our governors. The office can be contacted by telephone on (0113) 8555900 or by email at ftmembership.lypft@nhs.net.

SECTION 6 – OUR AUDITORS

6.1 EXTERNAL AUDIT SERVICES

In 2017/18 our external auditors changed from PricewaterhouseCoopers LLP to KPMG. The Council of Governors approved the appointment of KPMG as our auditors with effect from 1 October 2017 following a full and robust tender process.

All members of the KPMG audit team are independent of the Board of Directors and of staff members. Each year the audit team provides a statement in support of the requirements for their objectivity and independence to the Audit Committee. The auditors provide audit services in accordance with the Code of Audit Practice. This covers the opinion on the annual accounts, financial aspects of corporate governance, the use of resources, the Annual Report and the Quality Report.

The cost of independent audits during 2017/18 is detailed in the table below:

Table 6A – Cost of statutory audits

The Annual Accounts	£49,000
The Quality Report	£8,8510
Total	£57,510

6.2 INTERNAL AUDIT SERVICES

Our internal audit services are provided by Audit Yorkshire. This is a specialist provider of internal audit services to the NHS. Audit Yorkshire was formed on 1 July 2016 from a merger of West Yorkshire Audit Consortium (WYAC) and North Yorkshire Audit Services (NYAS). WYAC and NYAS previously worked in partnership to provide our internal audit service and had signed a Memorandum of Understanding to support this.

The Internal Audit Team is led by Helen Kemp-Taylor who is the Managing Director and Head of Internal Audit. She is supported by Sharron Blackburn (CPFA) as Client Manager. Sharron is the Deputy Head of Internal Audit. The remaining team of auditors and specialists is drawn from across Audit Yorkshire.

The scope of the work of internal audit is to review and evaluate the risk management, control and governance arrangements that we have in place, focusing in particular on how these arrangements help it to achieve our objectives. The audit opinion may be used by the Accounting Officer to support the Annual Governance Statement. This is achieved through a risk-based plan of work, agreed with management and approved by the Audit Committee. Internal Audit is only one source of assurance and it works closely with other assurance providers, such as external audit and Local Counter-fraud Services, to ensure that duplication is minimised and a suitable breadth of assurance obtained.

PART B
THE QUALITY REPORT
2017/18

CONTENTS

PART B – QUALITY REPORT

PART 1 – STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

Leeds and York Partnership NHS Foundation Trust is the main provider of specialist mental health and learning disability services in Leeds. We also provide specialist services across York, the Yorkshire and Humber region, and some highly specialised national services.

In November 2017 our Trust Board approved our new Trust Strategy which sets out our vision to provide outstanding mental health and learning disability services as an employer of choice. This means supporting our service users and carers, our staff and the communities we serve to live healthy and fulfilling lives where we can all achieve our personal and professional goals, and live free from stigma and discrimination. Our strategy has been driving our work since then and is now supported by a set of strategic plans which describe in more detail the work we will do in the coming years to achieve our vision.

Our strategic plans are:

- Quality
- Clinical Services
- Estates
- IM&T
- Workforce and Organisational Development

We have continued to roll out and embed our Trust values which inform how we behave with each other, with service users, carers, partners and the communities we serve. I am very proud of the work we have done on our vision and values and I see evidence every day of our staff living them to the full.

- **We have integrity**
  We treat everyone with respect and dignity, honour our commitments and do our best for our service users and colleagues.

- **We keep it simple**
  We make it easy for the communities we serve and the people who work here to achieve their goals.

- **We are caring**
  We always show empathy and support those in need.

Service users are at the heart of everything we do. We constantly strive to offer them the best possible support and provide effective, accessible and modern healthcare.

We work with our partners to tackle the stigma and discrimination often faced by people with mental ill health and learning disabilities. We are incredibly proud of the partnerships we have with our service users, carers and their families as well as third sector providers, commissioners, other NHS organisations, primary care, the local authority and the police.

In this report, we describe the quality improvements we have made over the last year and how these have contributed towards the achievement of our strategic objectives:

1. We deliver great care that is high quality and improves lives.
2. We provide a rewarding and supportive place to work.
3. We use our resources to deliver effective and sustainable services.

It has been a busy year, which is reflected in the report. We have been working hard to make improvements in direct care and redesigning services to improve access. We have also been developing the infrastructure and governance to support quality at the front line and provide assurance to our Board and Council of Governors on the work we are doing.

Our most recent CQC inspection (carried out between 8 January and 31 January 2018) recognised this work with positive feedback on our culture, leadership and governance. This included our new way of learning from deaths, working with families and carers as part of our commitments to duty of candour and supporting staff to learn from incidents to make improvements. We have now been rated as 'Good' for the well-led component of our inspection which gives external validation for the work we have done in the past 12 months. Across our corporate and clinical services there are lots of examples of improvements, for example: the investment in leadership through our Mary Seacole programme and Senior Leaders' Forum; improvements in our staff survey results; and the redesign of our community learning disability service to provide more seamless care and a new crisis support service for people with a learning disability.

Our Specialist Supported Living Service was inspected by the CQC and improved from 'Requires Improvement' to 'Good Overall' and 'Outstanding' for caring of which I am very proud. Similarly, our crisis and health-based places of safety have improved their ratings to 'Good' across the board from 'Requires Improvement' and our National Inpatient Centre for Psychological Medicine (NICPM) is now rated 'Outstanding' for caring and effectiveness. There is still more to do of course. We need to better demonstrate the excellent work our acute inpatient and psychiatric Intensive Care Service is doing through initiatives such as 'safe wards', which have shown a reduction in incidents of violence and aggression and the use of restraint. The CQC rating for this service went from 'Good' to 'Requires Improvement' during our latest inspection, but the team is already well underway addressing the actions in relation to safety and effectiveness to get back to 'Good'. Our Forensic and learning disability inpatient services remain at 'Requires Improvement'. I know our staff are working hard in these services in what are challenging circumstances.

We are proud that our work has been recognised with a host of awards and nominations over the last 12 months. These accolades include a Health Service Journal Award nomination for our Communications Team for the engagement work they did to support our strategy refresh. Two of our services were highly commended at the national Positive Practice in Mental Health awards, our Yorkshire Centre for Eating Disorders and our specialist Personality Disorder services. Our Perinatal Service achieved accreditation with the Royal College and I have lost count of the number of individual awards and nominations for staff throughout the year, both externally and internally, through our monthly star awards and overall Trust awards which was held in November 2017. We had another record number of entries and celebrated ten winners on the night including bank staff of the year and leader of the year.

We have been honest about our successes and also about where our performance has fallen short of expectations. Developing our culture based on our values is essential to being open and transparent and this remains our number one priority going forward. We continue to seek feedback, to learn and to improve the quality of care we provide to our service users, their families and the communities we serve. That is why this Quality Report also sets out our ambitions for 2018/19 which were approved by our Trust Board in April 2018.

I am happy to state that, to the best of my knowledge, the information included in our Quality Report is accurate.

Dr Sara Munro
Chief Executive

PART 2 – PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

2.1 PRIORITIES FOR IMPROVEMENT

In November 2017 The Leeds and York Partnership Foundation Trust (LYPFT) launched its revised Trust Strategy: *Improving health, Improving lives*, which describes what we want to achieve between 2018 and 2023 and how we plan to get there. Our Quality Report is fully aligned with our Trust Strategy and sets out some examples of the progress we have achieved and our future initiatives.

Our new organisational strategy used a crowdsourcing approach to reimagine our vision, values and strategic objectives. This has given us the opportunity to go back to people who use our services, carers, staff and partners to help develop and agree: a new vision and ambition; three simple objectives that describe the outcomes we aspire to; and the values we will work to.

Table 1 - Our new strategic objectives and priorities for action by 2022/23

	Strategic objective	Priority actions
1	We deliver great care that is high quality and improves lives.	• Supporting people in their recovery • Supporting people to achieve their agreed goals and outcomes • Supporting staff to promote and coordinate helpful and purposeful practice
2	We provide a rewarding and supportive place to work.	• Recruitment, retention, reward and talent management • Embedding values and behaviours to deliver cultural change • Staff support and health and wellbeing
3	We use our resources to deliver effective and sustainable services.	• Best use of technology and estate

Our strategic intent is set out in our Trust Strategy (2018-2023) and our one-year Operational Plan (2018-2019). Both of these key documents have been fully aligned with the key themes from national and local strategies and recognise the challenges and opportunities we see ahead over the next one to five years. We will continue to work alongside commissioners and providers both locally and regionally in order to develop integrated strategic objectives and plans.

All of our objectives and priorities will continue to be tracked through our governance framework to make sure we are on course to achieve them. The Trust Board and Council of Governors will receive regular reports on the progress we are making against our priorities set out in this year's Quality Report and the impact this is having for our service users, carers and staff.

In January 2018 the Board approved the Trust's Quality Strategic Plan. This is one of five strategic plans which underpin and support our Trust strategy. These five underpinning strategic plans have been used to identify our quality initiatives for 2018/19.

We have established a quality exchange forum which meets two to three times a year. This gives all services an opportunity to hear and share their quality improvement ideas and plan across the wider organisation.

Our Trust strategy for 2013 to 2018 identified our overarching priorities as:

Priority 1 (clinical effectiveness)	People achieve their agreed goals for improving health and improving lives
Priority 2 (patient safety)	People experience safe care
Priority 3 (patient experience)	People have a positive experience of their care and support

Priority 1 was discussed with the Council of Governors on 14 February 2018, where the majority agreed that this should be an area of focus in this year's Quality Report. This will be the final year that Priorities 1, 2 and 3 will be reported in the Quality Report in this format. Next year's report will be aligned with our new Trust Strategy, along with our underpinning strategic plans and priority areas.

A summary table of our local and national indicators which are included in this report can be found in section 3.7.

2.1.1 Progress against 2017/18 initiatives for Priority 1 (clinical effectiveness) - people achieve their agreed goals for improving health and improving lives

2.1.1.1 Ensure our services, where appropriate, are accredited with nationally recognised bodies

The Trust is registered with several nationally recognised bodies. For the purposes of this year's Quality Report, the Care Quality Commission carried out a well led inspection of the organisation between 8 January and 31 January 2018. Further details of this visit can be found in section 2.2.5.

2.1.1.2 Demonstrate that our services have assessed and determined where NICE guidance is relevant and plans are in place to implement it

The Trust is committed to providing high quality care which is evidence-based where possible and guided by the National Institute for Health and Care Excellence (NICE).

The Trust implementation of NICE guidance was audited during 2018. The objective of the internal audit was to provide assurance on the Trust's processes for implementing NICE guidance and monitoring the impact and outcomes. The progress of the action plan was reviewed during March 2018.

On the recommendation of the internal auditors, our processes were reviewed and updated in a new procedure which sets out the Trust's framework for the review, dissemination, implementation and monitoring of relevant NICE Guidance and NICE Quality Standards so that:

- Clinicians are supported in the delivery of evidence-based, safe, quality care;
- Equity of care is promoted across the Trust;
- Declarations of compliance can be made to the commissioners within the agreed deadline
- Associated risk can be identified where guidance cannot be fully implemented.

2.1.1.2.1 Process for identifying and disseminating relevant documents

The Clinical Audit and Effectiveness Team (CAET) circulate NICE guidelines to identified NICE Leads, Clinical Directors and Service Managers. The CAET will also present the lists of newly published guidelines at the service level and care services clinical governance meetings. The identified NICE or Clinical Leads and Managers have eight weeks to review the guidance for relevance, and recommend one of the following:

- Relevant
- Informs practice
- Not relevant.

The CAET collates individual feedback from teams and services and reports to the Clinical Audit and NICE Guidance Group (CA&NG) to generate recommendations for approval by the Trust Wide Clinical Governance Committee (TWCG).

The outcome of relevance determination is notified to Trust staff via the Trustwide twice weekly staff bulletin by the Library and Knowledge Service (LKS).

2.1.1.2.2 Process for conducting an organisational baseline assessment

Only guidance assessed as 'relevant' progresses to a baseline assessment. A baseline assessment will begin within six months of guidance being assessed as relevant and usually lasts about four months. The CAET supports NICE leads in each service to conduct baseline assessments. The process for escalation if baseline assessments are not completed is:

- The CAET staff will discuss barriers to conducting the base line assessment with the allocated NICE Lead
- The CAET will contact the relevant Clinical Director if the situation cannot be resolved
- Discuss at the CA&NG group and escalate to TWCG if required.

2.1.1.2.3 Declaration of compliance

The baseline assessment provides an understanding of whether current practice or service provision meets the recommendations of the guidance. Compliance can be declared as:

- Compliant
- Non-compliant – **r**equires an action plan

2.1.1.2.4 Process for recording of any decisions not to implement NICE recommendations

If a decision is made that a particular NICE guideline will not be implemented due to clinical decision, resource deficits or funding gaps, this will be formally noted in team and care group clinical governance minutes. The identified leads will ensure that any risk posed by non-implementation is assessed and escalated.

i. Any decision not to implement a guideline and reasons for the decision is referred to CA&NG Group and TWCG Group.
ii. The Medical Director will escalate any decisions not to implement NICE guidance to the Trust Board.
iii. Once the Board validates the non-implementation, any associated risks will be added to the Trust Risk Register.
iv. CAET will contact the identified leads on a six monthly basis to determine whether there are any changes in the decision not to implement the guidance. CAET will then update the database accordingly.

2.1.1.2.5 Process for ensuring that recommendations are acted upon throughout the Trust

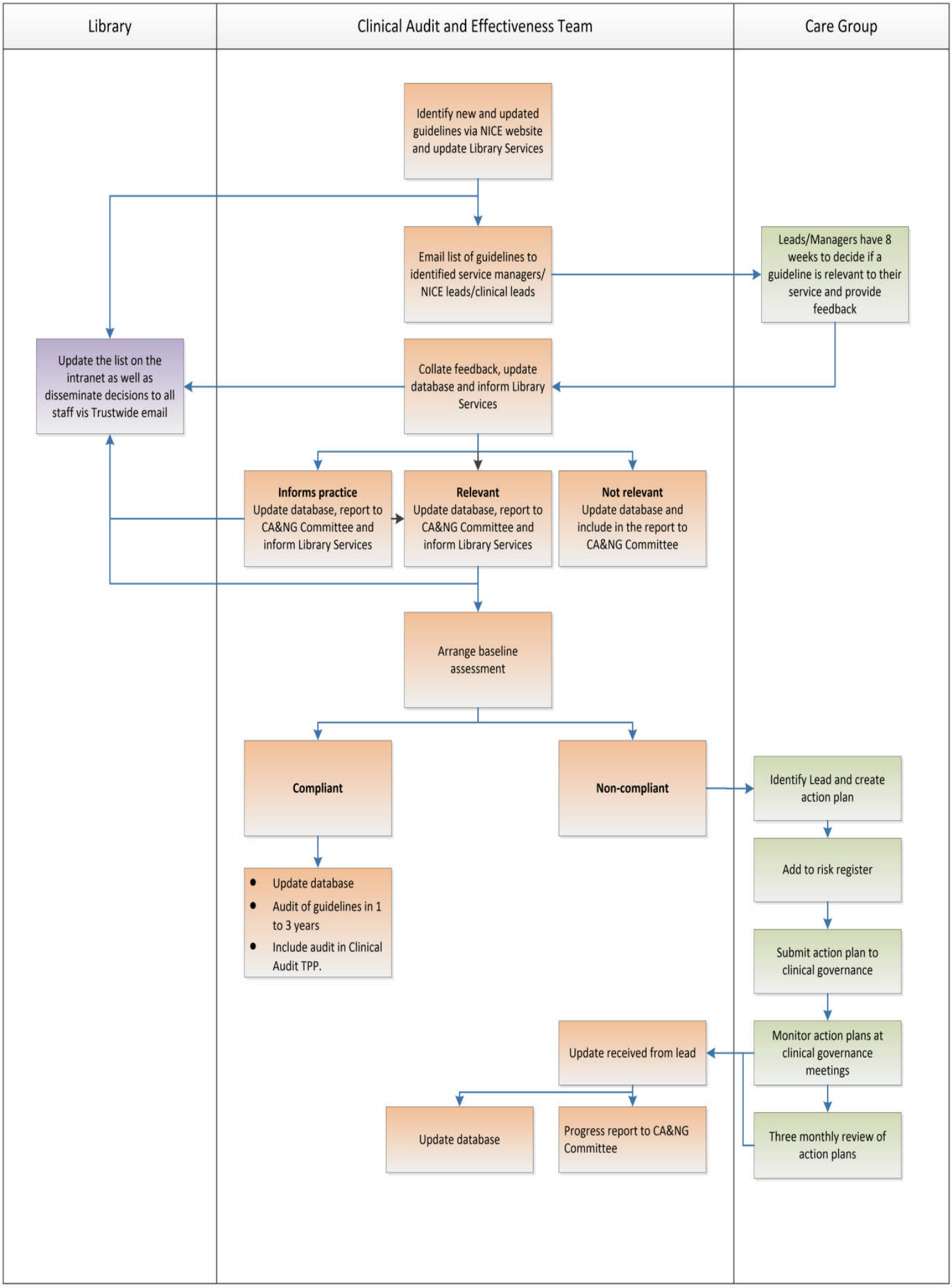
Where required, an action plan will be developed to address any deficiencies in compliance. The action plan should include financial implications of any proposed changes and recommendations about the scope and frequency of clinical audit to be conducted. Recommended NICE audit activity will be added to the Trust Clinical Audit Priority Plan. Each service's clinical governance group is responsible for ensuring they have an action plan to address any deficiencies in compliance.

The progress with the action plan will be monitored by the following groups and outcomes recorded in the minutes of each group.

i. Service or team clinical governance groups
ii. Care group clinical governance groups
iii. CA&NG group

Each year, as part of the Clinical Audit Trust Priority Plan (TPP), agreement will be reached with Clinical Directors and clinical governance groups about plans for NICE audits. This agreement will consider results/compliance of previous audit activity and the need to assure compliance through re-audit. Actions from NICE clinical audits are disseminated to staff.

Figure 1 - Flowchart of NICE implementation procedure


Library
Clinical Audit and Effectiveness Team
Care Group
Identify new and updated guidelines via NICE website and update Library Services
Email list of guidelines to identified service managers/ NICE leads/clinical leads
Leads/Managers have 8 weeks to decide if a guideline is relevant to their service and provide feedback
Update the list on the intranet as well as disseminate decisions to all staff vis Trustwide email
Collate feedback, update database and inform Library Services
Informs practice
Update database, report to CA&NG Committee and inform Library Services
Relevant
Update database, report to CA&NG Committee and inform Library Services
Not relevant
Update database and include in the report to CA&NG Committee
Arrange baseline assessment
Compliant
Non-compliant
Identify Lead and create action plan
Add to risk register
Submit action plan to clinical governance
Monitor action plans at clinical governance meetings
Three monthly review of action plans
Update received from lead
Update database
Progress report to CA&NG Committee
Update database
Audit of guidelines in 1 to 3 years
Include audit in Clinical Audit TPP.

Key:

CAET - Clinical Audit and Effectiveness Team
CG - Care Groups
CA&NG Group – Clinical Audit and Nice Guidance Group
LKS – Library and Knowledge Services

2.1.1.2.6 NICE guidance baseline assessment and compliance

During 2017/18 NICE published 220 new or reviewed pieces of guidance. Between April and December 2017, services within the Trust reviewed 164 pieces of NICE guidance. Between January and March 2018, 56 pieces of NICE guidance were reviewed. The services identified 12 guidelines relevant to the Trust and 37 guidelines for information to practice.

Table 2 – NICE guidelines relevant to the Trust services (April-December 2017)

Month	Reference	Title	Type
April	QS149	Osteoporosis	Quality Standard
April	CG100	Alcohol-use disorders: diagnosis and management of physical complications	Clinical guideline
May	NG69	Eating disorders: recognition and treatment	Clinical guideline
June	QS154	Violent and aggressive behaviours in people with mental health problems	Quality Standard
August	CG192	Antenatal and postnatal mental health: clinical management and service guidance	Clinical guideline
August	CG32	Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition	Clinical guideline
September	CG28	Depression in children and young people: identification and management	Clinical guideline
September	QS159	Transition between inpatient mental health settings and community or care home settings	Quality Standard
October	CG89	Child maltreatment: when to suspect maltreatment in under 18s	Clinical guideline
October	NG76	Child abuse and neglect	Social Care guideline
December	CG128	Autism spectrum disorder in under 19s: recognition, referral and diagnosis	Clinical guideline
December	TA494	Naltrexone–bupropion for managing overweight and obesity	Technology appraisal guidance

The Trust services declared compliance with six projects shown in the following table.

Table 3 – Declaration of Compliance (April 2017-March 2018)

ID	Title	Declaration agreed
NG015	Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use	21/02/2018
NG046	Controlled drugs: safe and effective management	04/05/2017
PH050	Domestic violence and abuse: multi-agency working	21/02/2018
NG056	Multi morbidity: clinical assessment and management	13/03/2018
TA494	Naltrexone-bupropion for managing overweight and obesity	22/02/2018
NG013	Workplace health: management practices	21/02/2018

The table below shows the target date for completion of declarations of compliance for guidelines identified as relevant where a baseline assessment is needed.

Table 4 – Baseline assessment in progress

ID	Title	Declaration to be agreed by
NG027	Transition between inpatient hospital settings and community or care home settings for adults with social care needs	31/12/2018
NG032	Older people: independence and mental wellbeing	31/12/2018
NG043	Transition from children's to adults' services for young people using health or social care services	28/02/2019
NG053	Transition between inpatient mental health settings and community or care home settings	31/08/2019
NG054	Mental health problems in people with learning disabilities: prevention, assessment and management	30/09/2019
NG055	Harmful sexual behaviour among children and young people	30/09/2019
NG058	Coexisting severe mental health illness and substance misuse: community health and social care	01/11/2019
NG064	Drug misuse prevention: targeted interventions	01/02/2020
NG067	Managing medicines for adults receiving social care in the community	01/03/2020
NG069	Eating disorders: recognition and treatment	23/05/2020

2.1.1.3 Have a clear audit plan to support the delivery of high quality care

Prior to the start of every financial year the Trust will agree an annual clinical audit programme. This plan focuses on the 'must do' activity within the Trust, reflecting both national and local priorities. The programme is drafted by the Head of Clinical Audit and Service Evaluation and presented to the CA&NC Group for review prior to submission to TWCG for approval. This programme should meet the Trust's corporate requirements for assurance, but must be owned by clinical services.

Table 5 – Requirements that will influence the Clinical Audit Programme

Level of requirements	List of requirements
National requirements	National Institute for Health & Clinical Excellence (NICE) National Clinical Audit/ National Confidential Enquiry into Patient Outcome and Death (NCEPOD) National Service Frameworks (NSFs) Guidelines from Royal Colleges Department of Health Standards National Audits Care Quality Commission Regulations
Trust requirements	Trends from clinical/ non-clinical incidents Information Governance requirements Requirements through contracts for the services we commission (CQUINS) Trends from complaints Issues identified from patient groups/service users/carers/Patient Advice and Liaison Service Issues raised through Risk Management Standards Cost effectiveness and value for money Service Development, Internal and External audit

Level of requirements	List of requirements
	Complaints/litigation – identified by Corporate Services Manager Risk Register / Assurance framework identified by Corporate Service Manager
Care group / service requirements	Practice/ Service/ Team improvement plans Previous audit outcomes Proposals from care groups / clinical teams

The Clinical Audit Programme is developed through a combination of managerial directives and service and team issues, with work prioritised as follows:

Priority 1 – 'Must do' projects. These are projects that are driven by commissioning and quality improvement and are treated as the priority by the Trust. Topics to include in this priority should be:

- New national targets and existing commitments
- National Clinical Audit and Patient Outcomes Programme (NCAPOP)
- Audits demonstrating compliance with regulation requirements e.g. audits with the aim of providing evidence of implementation of NICE technology appraisals, clinical guidelines and public health guidance, NSFs and other national guidance such as that coming from National Patient Safety Agency (NPSA) alerts or NCEs
- CQUINS and other commissioner priorities
- NHS England statutory requirements, such as infection control monitoring
- External accreditation schemes
- Re-audits of any of the above.

Priority 2 – Internal 'must do' projects. These fulfil the classic criteria of high risk or high profile projects identified by Trust management or Trust Wide Clinical Governance. They may include national initiatives with Trust-wide relevance, but no penalties exist for non-participation. Many of these projects will emanate from Trust governance issues or high profile local initiatives and will include:

- Clinical risk issues
- Serious untoward incidents/adverse incidents
- Organisational clinical priorities
- Priorities identified via Patient and Public Involvement initiatives
- Complaints
- Access
- Patient Safety
- Claims and other legal processes e.g. inquests
- Re-audits of any of the above.

Priority 3 – Care Groups are asked to suggest audits that are priority pieces of work and important to them, classified as local priorities. They may include NHS England initiatives and be care group specific. Priorities may include:

- Local clinical audits agreed by the Clinical Governance Care Groups as a priority

- National audits not part of National Clinical Audit and Patient Outcomes Programme (NCAPOP), e.g. some Royal College initiated projects lie outside of NCAPOP

- Locally adopted clinical standards benchmarking

- Re-audits of any of the above.

Priority 4 – Clinician interest. The priorities set up above should not stifle audits that emerge during the year that contribute to improvements in care. Some of these audits registered later in the year will slot into one of the above categories. However, there will be a number of audits that will not fall into any of the above priorities. It is fully recognised that there is a need to maintain a degree of locally initiated audits. These projects often cannot be determined at the outset of the financial year. They represent innovative ideas from clinicians and can provide valuable educational experience for junior staff. The Trust is committed to supporting locally determined clinical audit activity to significantly contribute to the process of the continuous service quality improvement. All those audits must be registered with the CAET.

Table 6 - Clinical Audit Priorities for 2018/2019

Trust priority topics	Code
Quality Account	A
National Clinical Audit & Patient Outcomes Programme (NCAPOP)	B
Standard NHS Contract	C
Commissioners	D
Trust Priority	E
Care Group	F

CAF	Priority	Project	Title	Care Groups	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Status
					04/ 17	05/ 17	06/ 17	07/ 17	08/ 17	09/ 17	10/ 17	11/ 17	12/ 17	01/ 18	02/ 18	03/ 18	
FG	A	111-18a	POMH-UK: Prescribing clozapine Lead: Richard Mellor	Trustwide													Data collection during June and July 2018
FG	A	111-6a	POMH-UK: Assessment of the side effects of dept tranquillisation Lead: Richard Mellor	Trustwide													The only information provided by the POMH-UK team is that the data collection will take place during October and November 2018
FL	F	2	Fall Audit (All wards at the Mount) Lead: Nicola Needham	Leeds Care Group													Data collection started in April 2018
FL	A&B	296	National audit of Anxiety and Depression Lead: Sophie Roberts (SLD) & Caroline Ispan (LMH)	Trustwide													Data collection: 4/06 - 07/09

	A&B	TBC	Psychological Therapies Spotlight Audit Lead: TBC	Trustwide														Data collection: 3/12/2018 - 25/01/2019. Report date: May 2019. Registration: August/September 2018
CAF	**Priority**	**Project**	**Title**	**Care Groups**	**Quarter 1**			**Quarter 2**			**Quarter 3**			**Quarter 4**			**Status**	
					04/ 17	**05/ 17**	**06/ 17**	**07/ 17**	**08/ 17**	**09/ 17**	**10/ 17**	**11/ 17**	**12/ 17**	**01/ 18**	**02/ 18**	**03/ 18**		
AM	E	361	CPA audit Lead: Sara Sewell	Trustwide														Data collection started in April 2018
CK	E	169	Safeguarding advice/referral audit Lead: Lindsay Britton-Robertson	Trustwide														Data collection started in May 2018
FG	E	TBC	Mental Capacity Act – Best Interests audit Lead: Oliver Wyatt, Angelena Moor	Trustwide														Data collection to start in December 2018
AM	D	188	National Mental Health CQUINS: collaboration with GP Lead: Sara Sewell	Leeds Care Group														Rolling Audit Project - required by commissioners. The data collection will start in Q3 and submit the report in Q4.
FL	D	187	National Mental Health CQUINS: cardio metabolic screening Lead: TBC	Trustwide														Lead to be confirmed by physical health CQUINs group two months prior to data collection
CK	C	54	IG Tool: Record Keeping Lead: TCB	Trustwide														Information to be provided by the end of February. Lead will be confirmed two months prior to data collection
AM	C	259	Data sharing: NICE Guidance	Trustwide														The data collection will start in December 2018

			138 Lead: Linda Rose														
CK	E	41	MEWS Lead: Michelle Higgins	Trustwide													The data collection will start in December 2018
FG	A	111	POMH- UK: TBC	Trustwide													Topic to be confirmed by POMH Team 1/2 way through the year
CAF	**Priority**	**Project**	**Title**	**Care Groups**	**Quarter 1**			**Quarter 2**			**Quarter 3**			**Quarter 4**			**Status**
					04/ 17	**05/ 17**	**06/ 17**	**07/ 17**	**08/ 17**	**09/ 17**	**10/ 17**	**11/ 17**	**12/ 17**	**01/ 18**	**02/ 18**	**03/ 18**	
FG	A	297	National Audit for Care at the End of Life (NACEL) Lead: Nicola Needham	Trustwide													Data collection: a) Organisational audit (June-October 2018); b) Carer Questionnaire (June-October 2018). Report to be produced in May 2019
	A&B	210	Learning disabilities Mortality Review Programme (LeDeR)	Trustwide													This is not a clinical audit but is included on the list because it is a project on the NCAPOP and reportable in the clinical audit section of the Quality Account (Risk Team responsible to collect information)
FG	A	111-17a	The use of depot/long-acting injectable (LAI) antipsychotic medication for relapse prevention Lead: Richard Mellor	Trustwide													79 cases submitted. National report received (18/01/2018)

FG	A	111-15b	Prescribing for bipolar disorder (use of sodium valproate) Lead: Richard Mellor	Trustwide													Data collection completed: 21 cases submitted
FG	A	16	National Audit of Psychosis	Trustwide													Reporting stage. Report to be submitted in June 2018
FL	A	254	NCEPOD Local Reporter:	Trustwide													Stage - Data collection - additional form to be collected - Report scheduled between December '17 - April '18
CK	F	220	Gatekeeping assessments (Forensics audit) Lead: Dr Adewusi	Trustwide													Data collection

2.1.1.4 Have a clear plan to support the research and development strategy in the organisation.

Section 2.2.3 contains further detailed information about the Trust's research and development activity.

2.1.1.5 Ensure that staff are trained to carry out the roles that are required of them and supported in their development

The Trust has consistently maintained high levels (above the target of 85%) of compulsory training compliance throughout 2017/18. Staff and teams have been supported to ensure compulsory training is completed by offering a variety of learning methods, including e-learning and face-to-face sessions delivered locally to teams.

The Trust has reviewed its appraisal system and embedded a co-created values and behaviours framework. The Trust's learning management system is now being used to support the electronic recording of appraisal outcomes, including development plans and in the future this will support departmental, Trust aggregation and analysis of training needs.

During 2017/18, the Trust has developed its approach to apprenticeships and in March 2018, 18 healthcare support worker apprentices commenced on placement in Trust services. In addition, the Trust is also supporting a small cohort of associate nurse apprentices and a variety of skills based training has been delivered to our clinical and non-clinical support staff.

During 2017, a review of the Trust induction took place and from 1 April 2018 all new starters attend a Trust welcome day. The main purpose of this day is to ensure new starters learn about the NHS, the Trust and gain a good understanding of our clinical services and can network with other new staff.

During 2018, the Trust has successfully developed and delivered a local version of the NHS Leadership Academy's Mary Seacole Programme. The programme, aimed at first-time or middle leaders will enable staff to develop their leadership behaviours and impact.

In 2017/18 a number of teams and services have been supported and developed to co-create plans and activities to deliver significant changes. This has included developing an approach to agile working, with key issues addressed including team working, clinical services, the environment and the use of technology. The learning from these plans will be used across the Trust to support other services facing similar changes.

2.1.1.6 Continue the development of outcome measures within the Trust

Measure: Clinical outcomes have been improved for people who use our services (CROMs).

Performance: During 2017/18, we have introduced a new streamlined Clinician Rated Outcome Measure (CROM) called the Clinical Global Impression Scale (CGI) which has been welcomed by clinicians as a simpler way of reporting service users' outcomes. Reports are available for compliance with completion of Health of the Nations Outcome Scales (HoNOS) and CGI and the current percentage completed is 62%. Individual clinicians are able to review outcome scores for each of their service users through a report in PARIS.

Following an engagement and implementation phase for the CGI in 2017 we are now in a position to build outcome reports for clinicians to review their entire caseloads collectively. This will enable teams to focus work with service users on interventions which can be demonstrated to have positive outcomes.

The Trust's memory services and the dementia inpatient services based at The Mount have been piloting the use of DEMQOL which is a patient reported outcome measure (PROM) and is designed to enable the assessment of health-related quality of life for people with dementia.

19 service users had their DEMQOL completed at the point of referral and again prior to discharge. The pilot showed wide variation in the administration and use of the tool.

Future use of DEMQOL will involve clinicians working within both memory services and dementia inpatient services, in order to use the data in a way which maximises understanding and use of the information. Examples are looking at how DEMQOL is administered by clinical staff and looking at good practice of how DEMQOL is used both regionally and nationally. It is proposed that the use of DEMQOL will be a topic for the new Older People's Service Clinical Governance Group and part of the Trust Wide Outcome Measures Group.

A Trust Wide Outcomes Group, established in February 2018, is reviewing best practice and sharing this across services by embedding and using outcome measures in clinical practice at individual and team level. This group will lead on the introduction of service user experience measures for all teams.

2.1.2 Progress against 2017/18 initiatives for Priority 2 (patient safety) - people experience safe care

2.1.2.1 Demonstrate that we have learnt lessons and introduced new practices through our review of incidents and complaints and publish this in our quality reports

How we learn from incidents:

A review of the last three years' Serious Incidents was completed in November 2017 to identify the key themes across the two care groups and to achieve a detailed understanding of the demographic information, and to formulate a better understanding of the learning and to identify any gaps in the action plans.

The decision to undertake an investigation is now agreed through the Learning from Incidents and Mortality Meeting (LIMM). This group agrees terms of reference and the allocation of the investigator. The Trust has recently changed the process of investigation to provide a supportive, compassionate approach to staff, with the introduction of 'Learning Reviews', therefore, where possible, avoiding one to one traditional interviews to enable teams to reflect and share learning.

An important element of this approach is for teams to highlight good practice and to establish any root cause or contributory factor for an incident. Staff have reported that they have found this approach supportive and that it enabled an open and honest discussion. In addition this approach ensures that teams are involved in the recommendations and action plan, rather than this being seen as something remote and removed from the team. This also avoids the issue of human error, evidenced in the RCA2 Improving Root Cause Analysis and Actions to Prevent Harm, which notes the importance of understanding that system and process change is key to preventing harm in the future, rather than a focus on an individual.

The themes identified by both care groups include:

- Systems/Processes/Procedures
- Workforce
- Treatment/Care Plan
- Documentation and Record Keeping
- Care Programme Approach (CPA) and Care Coordination
- Service User / Carer Involvement

The detail within the themes includes:

- unclear pathways
- poor written, electronic and verbal communication between professionals- both internal and external
- a lack of guidelines to support clinical practice
- high workload of care coordinators
- risk training
- standards of record keeping including documentation of MDT (multi-disciplinary team) discussing absence of family in care because there is little or no carer engagement.

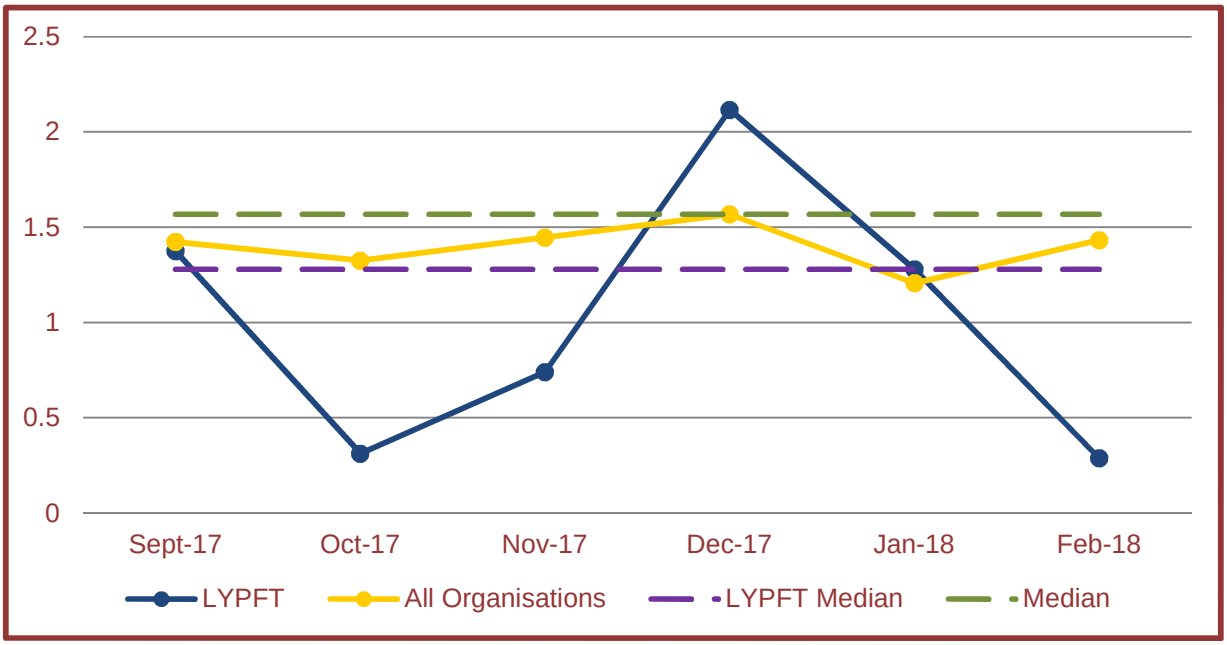
2.1.2.2 Demonstrate how we have changed practice based on themes identified through the Mental Health Safety Thermometer

The Mental Health Safety Thermometer is a national tool that has been designed to measure commonly occurring harms in people that engage with mental health services. The tool allows harm to be measured and the proportion of patients that are harm free, including self-harm, psychological safety, violence and aggression, omissions of medication and restraint (inpatients only).

The data collected forms a paper that is part of the quality compliance between the care groups, LYPFT and Leeds CCG to provide an overview of performance, learning and actions from the last six months; with the aim of reducing the number of harms and so improve patient experience.

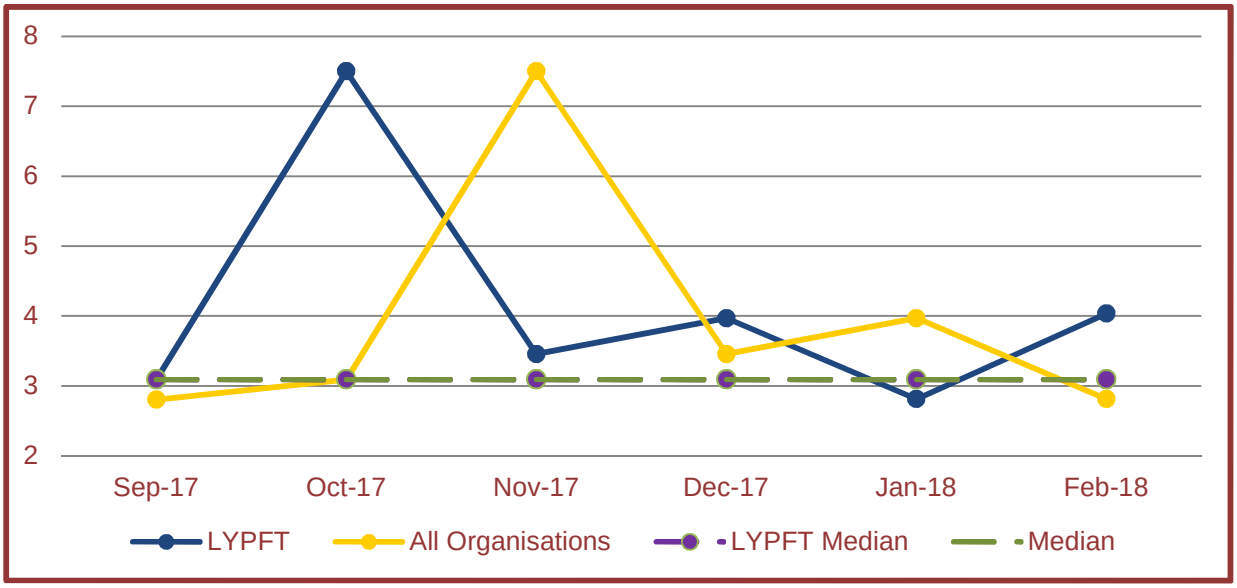
During this review period, September 2017-February 2018, 4 out of 30 wards/services were 100% harm free, and 17 further services were more than 80% harm free.

Figure 2 – Proportion of patients that have been the victim of violence / aggression in the last 72 hours



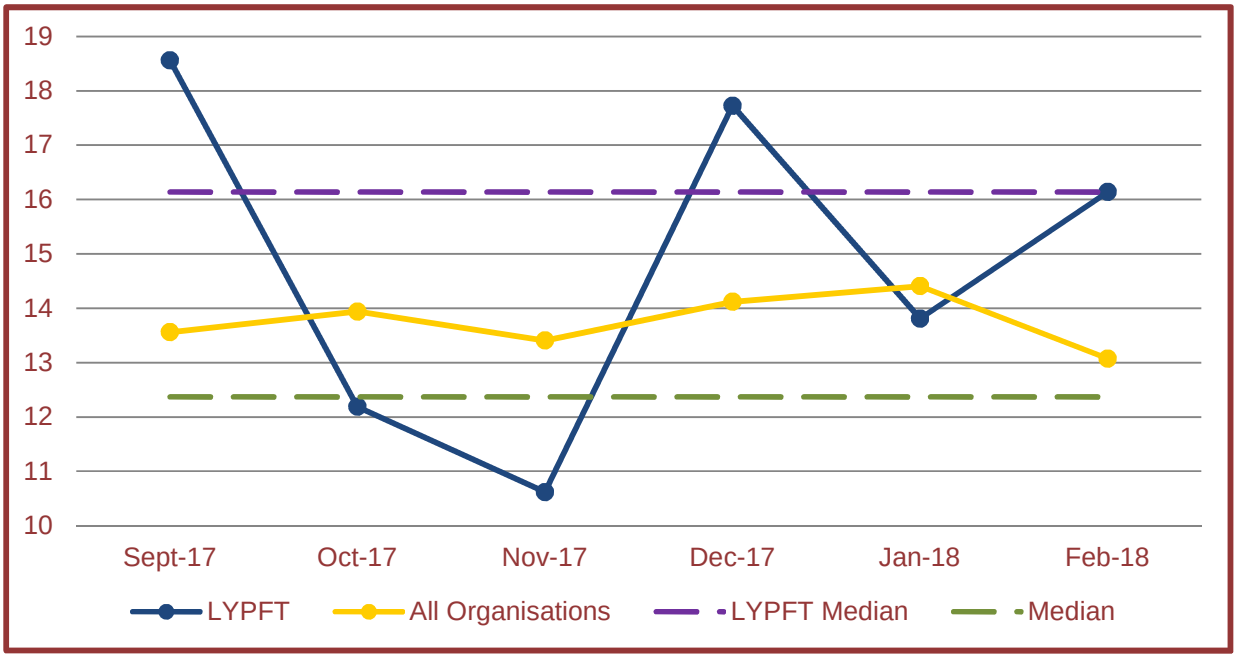
The experience of LYPFT patients has been more varied over this six month period than for all organisations combined. However, our median score is lower than the national median. There was a peak of violence in December, which we know can be a difficult time for patients and services, with increased reporting noted as a result of system-wide pressures and an increase in out of area placements. Despite December having an increased number of victims of violence, it was also recorded as having the highest proportion of patients who felt safe.

Figure 3 – Proportion of patients that have self-harmed in the last 72 hours



The median for patients who had self-harmed at the Trust was the same as the median for all organisations for this period. There were 18 wards/services where patients were recorded as having self-harmed. The majority of incidents were at Mill Lodge, which we know has a high level of self-harm, and the peak in October was mainly related to one or two patients at the service. Parkside Lodge also has several patients who display these behaviours consistently.

Figure 4 – Proportion of patients that have had an omission of medication in the last 24 hours



The median score for the Trust is much higher than the figure for all organisations, indicating a higher number of omissions than other organisations. However, results are more sporadic, and November showed a very low number of omissions, but September and December were very high.

The themes of this data have indicated two areas of practice to improve which are: improve compliance of the point prevalence data collection and submission across all areas and to share this report and monitor action plans and progress within the care group governance structures.

2.1.2.3 Evidence that we have applied the learning from our mortality reviews

The National Quality Board published its document on 'Learning from Deaths, a framework for NHS trusts and NHS foundation trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care' in March 2017. This was as a result of the Mid Staffordshire mortality review and subsequent review of 14 hospitals with high mortality rates. The purpose of the document was to initiate a standard approach to learning from deaths and to establish practical steps to reduce "avoidable" deaths.

The Trust has worked with eight other mental health and learning disability trusts across the northern region, supported by Mazars, to develop a standardised approach for reporting deaths. This includes the development of a tool to aid mortality reviews by providing identification and categorisation of deaths for investigation.

The Trust initially undertook monthly mortality reviews. However, it was recognised that these reviews were not robustly recorded and did not use any specific coding system. In July the advent of the Learning from Mortality and Incidents Meeting (LIMM) led to deaths being reviewed on a weekly basis, for all service users receiving care from the Trust within the last 6 months.

These meetings are now formally recorded, including an action log. Initially the deaths reviewed were just those reported on the Datix incident reporting system, category 5. However, it was recognised that this did not provide assurance that all deaths were captured and from 1 September 2017, LIMM began to review deaths linked to the Trust from the NHS Spine on a weekly basis. This provides greater assurance that we know about all of our deaths. A review of all patients identified as having died in August on the NHS Spine was also undertaken. These patients are not included in the Quarter Two data as they were reviewed outside of LIMM.

LIMM includes medical staff and representation from both care groups. All service users with a learning disability are discussed, reported to LeDer and a review of their care is undertaken using the LeDer reporting system.

The meeting considers all deaths where the cause of death has been confirmed. Where this is not the case, the service user's death remains on the action log for discussion when this information is available. To ensure timely discussion, the administrator contacts the patients' GPs and the Coroner's Office to establish cause of death.

Each death is coded using the Mazar tool. LIMM subsequently agrees if any further investigation is required, using the stratification below which was introduced in December 2017:

Table 7 – Stratification used to agree whether further investigation is required

Code	Classification	Description
EN1	Expected Natural Death	A death that was expected to occur in an expected time frame
EN2	Expected Natural Death	A death that was expected but was not expected to happen in the time frame
UN1	Unexpected Death	Unexpected death which is from natural cause

Code	Classification	Description
UN2	Unexpected Death	Unexpected death which did not need to be: e.g. some alcohol dependence
UU	Unexpected unnatural death	A death from unnatural cause e.g. suicide, homicide.
EU	Expected unnatural death	A death that was expected but not from the cause or the timescale
NOD	LYPFT not the primary provider of care	Not the primary provider of care at the time of death or not in receipt of Trust services six months prior to death

All deaths coded as UU, or where a family member or staff have raised concerns, will initiate a comprehensive LIMM investigation utilising Root Cause Analysis RCA tools.

In addition to the above, the Trust provides training for the use of Structured Judgement Review case note methodology. This enabled themes and trends to be identified and will provide, where appropriate, more depth to the mortality review process and reduce variation in reviews. The training took place in November 2017 and Structured Judgement Reviews began in January 2018.

2.1.2.3.1 The number of patients who have died during the reporting period (including a quarterly breakdown of the annual figure)

During the period 1 April 2017 to 31 March 2018, 452 Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

72 in the first quarter
66 in the second quarter
151 in the third quarter
163 in the fourth quarter.

NHS spine data was available from Q3 onwards, with the impact of having access to more robust triangulated data being seen in the increase numbers of deaths reported in Q3 and Q4.

The tables below show the number of deaths which occurred in each quarter of that reporting period as per the codes above.

Table 8 – Total number of deaths reported in Q1

Total number of deaths reported in Q1	72
Process for categorisation in development during Q1	

Table 9 – Total number of deaths reported in Q2

Total number of deaths reported in Q2	66
Awaiting cause of death confirmation	8
NOD (LYPFT not the primary provider of care)	21
ENE 1 (Expected Natural Death - expected to occur within a timeframe)	16
ENE 2 (Expected Natural Death - expected death but not expected in the timeframe)	11
UN 1 (Unexpected Death from Natural Causes i.e. cardiac arrest/stroke)	2
EU (Expected Unnatural Death i.e. alcohol or drug dependency)	0
UN 2 (Unexpected Natural Death from natural cause but did not need to be)	11
UU (Unexpected Unnatural Death)	6

Table 10 – Total number of deaths reported in Q3

Total number of deaths reported in Q3	151
Awaiting cause of death confirmation	2
NOD (LYPFT not the primary provider of care)	114
ENE 1 (Expected Natural Death - expected to occur within a timeframe)	12
ENE 2 (Expected Natural Death - expected death but not expected in the timeframe)	10
UN 1 (Unexpected Death from Natural Causes i.e. cardiac arrest/stroke)	3
EU (Expected Unnatural Death i.e. alcohol or drug dependency)	0
UN 2 (Unexpected Natural Death from natural cause but did not need to be)	2
UU (Unexpected Unnatural Death)	10

Table 11 – Total number of deaths reported in Q4

Total number of deaths reported in Q4	163
Awaiting cause of death confirmation	13
NOD (LYPFT not the primary provider of care)	134
ENE 1 (Expected Natural Death -Expected to occur within a timeframe)	5
ENE 2 (Expected Natural Death - Expected death but not expected in the timeframe)	7
UN 1 (Unexpected Death from Natural Causes i.e. cardiac arrest/stroke)	1
EU (Expected Unnatural Death i.e. alcohol or drug dependency)	1
UN 2 (Unexpected Natural Death from natural cause but did not need to be)	1
UU (Unexpected Unnatural Death)	1

2.1.2.3.2 The number of deaths included above which have been subjected to a Structured Judgement Review or an investigation to determine what problems (if any) there were in the care provided to the patient (including a quarterly breakdown the annual figure)

By January 2018, 12 Structured Judgement Reviews and two investigations have been carried out in relation to 452 of deaths included in item 1. In two cases a death was subjected to both a case record review and investigation. In addition, 19 retrospective, random Structured Judgement Reviews were carried out in Q4 within our memory and care homes service, for service users who had died between 1 April 2017 and 31 January 2018. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

1 in the first quarter
1 in the second quarter
5 in the third quarter
24 in the fourth quarter

The Trust commenced Structured Judgement Reviews (SJR) in January 2018 following a training event led by NHS Improvement.

The table below shows the number of Structured Judgement Reviews, Serious Incidents and Concise Investigations completed, broken down by quarters:

Table 12 – Structured Judgement Reviews, Serious Incidents and Concise Investigations completed

	Structured Judgement Reviews	Serious Incidents	Concise Investigations
Qtr. 1	1	5	2
Qtr. 2	1	4	
Qtr. 3	5	9	
Qtr. 4	5 + 19 random care home cases	1	
Total	**12 + 19 = 31**	**19**	**2**

2.1.2.3.3 An estimate of the number of deaths during the reporting period included in item 1 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.

It is acknowledged nationally that there is not the same robust measurement and categorisation of inpatient deaths within Mental Health Trusts as there are in Acute Trusts. As a result it is difficult to draw meaningful conclusions from the available evidence.

Eight of the patient deaths during the reporting period (representing 1.77%) are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

1 representing 1.38% for the first quarter
2 representing 3.03% for the second quarter
5 representing 3.31% for the third quarter
0 representing 0% for the fourth quarter (investigations not yet complete).

These numbers have been estimated using the Structured Judgement Review and our serious Incident investigation process.

The Trust has worked with eight other mental health and learning disability trusts across the northern region, supported by Mazars, to develop a standardised approach for reporting deaths. This includes the development of a tool to aid mortality reviews, to provide identification and categorisation of deaths for investigation.

All service users with a learning disability who die are discussed and reported to LeDer, with a review of their care being undertaken using the LeDer reporting system.

The Trust's review process started in January 2018 and is evolving. To date 12 reviews have been initiated, with 10 being fully completed and the remaining two currently being reviewed using the Structured Judgement Review methodology. Many examples of excellent practice have been identified as part of the Trust's review process, with no significant problems with care being noted within these reviews.

In addition, a review of 19 case notes for the memory services and care homes teams has been completed using our Structured Judgement methodology in order to provide learning from deaths in this cohort of service users. This includes where the Trust is not the primary provider of care but has some input into the service users' ongoing mental health needs. Whilst learning was identified in these 19 cases, there were no problems with care noted in any way which contributed to the death of a service user.

2.1.2.3.4 A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 2.

Themes from the Structured Judgement Reviews (SJR) from January to March 2018 are as follows:

- Communication between Forward Leeds and the Trust for service users accessing both services. The two services have shared the findings of the SJR and work is in progress to improve the dual diagnosis pathway
- Delay from referral to initial assessment within one community service. This has been shared as part of a learning review with the community mental health team.
- Gaps in staff knowledge with regards to the National Early Warning Score. This is part of a Trust-wide work plan to improve and update staff's knowledge of clinical observations. A revised observation chart has been developed, which will address a number of the concerns noted as part of the reviews.
- Excellent practice was noted regarding the physical health needs of service users within the community mental health team. This was shared with the team.

2.1.2.3.5 A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item 3).

The Trust has a steering group, which commenced in January 2018 to further develop learning from incidents and deaths throughout the organisation, recognising this is challenging in a geographically spread Trust. The group includes senior members from Forward Leeds to ensure that learning is shared across the two organisations.

Following a Serious Incident, a learning review now takes place with the teams involved, to reflect on the incident and determine what could have been done differently. The investigation report is then shared with the teams when complete as a further learning review. These have been positively received by those involved.

The steering group plans to develop a Learning from Incidents Safety Alert and is revising the Learning from Deaths Policy. The Trust continues to work with the eight mental health trusts in the northern region to share learning wider than just Leeds. A patient safety event is planned for autumn 2018 to celebrate good practice and share learning from the serious incidents and reviews.

Several reviews highlighted learning at the point a service user transitioned from one service to another, at the time of discharge from hospital to community teams. Because of this learning, work has started on remodelling the community services to provide an increased support period at the point of this transition.

2.1.2.3.6 An assessment of the impact of the actions that have been learnt which were taken by the provider during the reporting period.

In September 2017 we developed a maturity matrix to identify our current position in relation to sharing and being able to demonstrate tangible change in practice. In September 2017 we were at Early Progress in development moving to Firm Progress in development by January 2018.

As a result of learning identified during the Serious Incident investigations or SJRs, a number of service improvements have occurred, such as the community redesign which focused on reducing the number of transitions between services and improved support following discharge from inpatient settings.

2.1.2.3.7 The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item 1 in the relevant document for that previous reporting period.

No case record reviews and no investigations completed after 1st April 2017 which related to deaths, took place before the start of this reporting period.

2.1.2.3.8 An estimate of the number of deaths included in item 7 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this.

None, representing 0%, of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the Mazars approach.

The Trust has worked with eight other mental health and learning disability trusts across the northern region, supported by Mazars, to develop a standardised approach for reporting deaths. This includes the development of a tool to aid mortality reviews, to provide identification and categorisation of deaths for investigation.

All service users with a learning disability who die are discussed and reported to LeDer, with a review of their care being undertaken using the LeDer reporting system.

2.1.2.3.9 A revised estimate of the number of deaths during the previous reporting period stated above of the relevant document for that previous reporting period, taking account of the deaths referred to above.

Zero, representing 0%, of the patient deaths during 1 April 2016 to 31 March 2017, are judged to be more likely than not to have been due to problems in the care provided to the patient.

This Trust along with other Mental Health Trusts, does not estimate deaths, this is something acute trusts do. Currently there is no evidence base to support mental health trusts to do this as we do not have the same number or types of deaths as acute trusts.

2.1.2.4 Embed clinical supervision in our services to support practitioners to practice confidently

In 2017/18 the Trust clinical supervision policy was reviewed. Clinical supervision activity to support individual role effectiveness and development has been audited and reviewed, to develop and nurture effective and consistent supervision practice for all staff.

Clinical supervision activity is being recorded on the Trust's learning management system and compliance with the Trust target of 85% is reported locally and Trust-wide. Monitoring of clinical

supervision compliance against the Trust target is monitored at care group and team level and through the Quality Committee.

2.1.2.5 Complete and implement a Training Needs Analysis identifying the requirements for staff to work with new models of care

Identification and delivery of future training and staff development needs are embedded in the Trust's project management approach to service change and re-design. Service re-design plans will include a work stream to ensure identified development needs are delivered. This supports staff to be able to transition to new roles and meet new service delivery models.

2.1.2.6 Implement our suicide reduction plan

A commitment to a reduction in suicide is a central purpose of our work in learning from deaths, near misses and incidents. We contribute to the *National Confidential Inquiry into Homicides and Suicides by people with mental illness (NCISH)* to inform the national evidence base with a 94% return rate for the year of this quality account. The local and national learning from these sources is used to shape both service redesign within the Trust and also cycles of continuous improvement.

In addition to our use of learning, we are supported by two plans: The Leeds Suicide Prevention Plan is a multi-agency plan underpinned by extensive local knowledge and an audit cycle that has developed a detailed understanding of the focus required locally. The West Yorkshire Suicide Prevention plan seeks to work within secondary mental health systems giving priority to local place-based plans.

An integration of these plans gives us an overarching framework of:

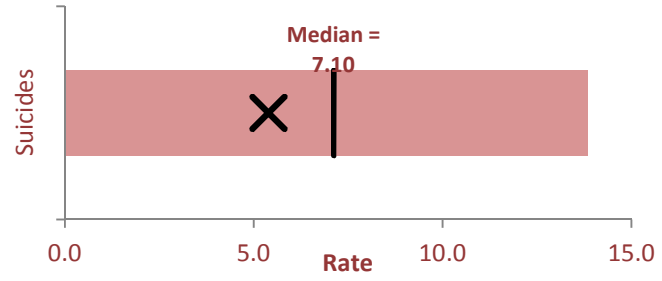
- Promotion and awareness of suicide prevention; integration of effort and intent
- Reduce risk of suicide in high risk groups including those who use mental health services, those who self-harm, people in specific groups as such as young people and men in their 30-50s as identified in the local audit
- Supporting primary care and non-mental health settings
- Joined up post-bereavement support
- Sensitive media reporting
- Continuous learning and research, the exploration of better and quicker joined up data to identified those at risk
- The use of measures to monitor progress

Work to date within the Trust has including specific work in areas such as crisis and liaison services, and the monitoring and improvement of performance around post-discharge.

There is a review of risk assessment and management training underway coupled with a program to improve the engagement of service users and their carers in active participatory safety planning alongside professional risk assessment.

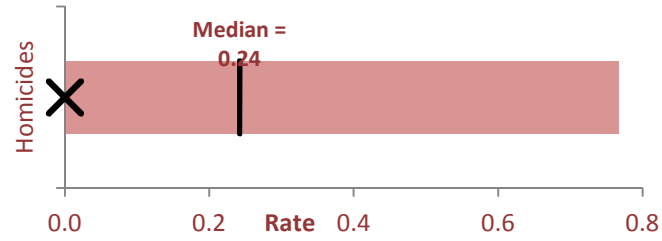
This is the first year that we have received the National Confidential Inquiry into Suicides and Homicides NCISH safety scorecard that reviews the work of the Trust on a range of data with association to suicide rates and this is shown below.

Figure 5 - Trust Scorecard: Leeds and York Partnership NHS Foundation Trust



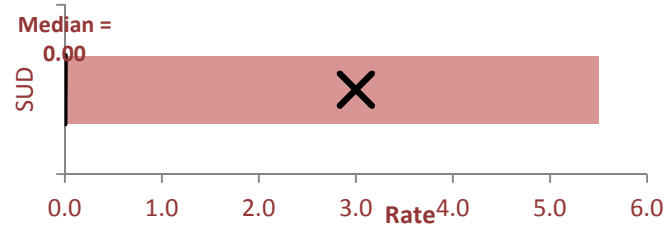
Suicide rate

The suicide rate in your Trust was 5.39 (per 10,000 people under mental health care) between 2013 and 2015.



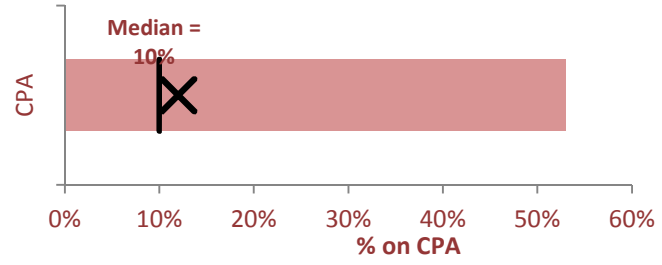
Homicide rate

The homicide rate was 0 (per 10,000 people under mental health care) between 2013 and 2015.



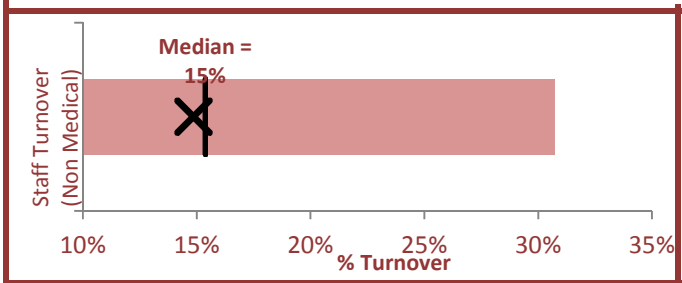
Sudden unexplained deaths (SUD)

The SUD rate was 3 (per 10,000 hospital admissions) between 2013 and 2015.



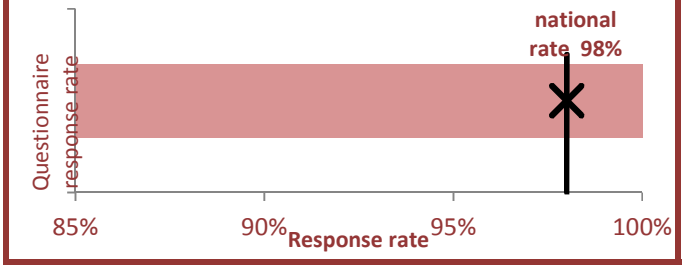
% on Care Programme Approach

The % of patients on CPA was 12% in 2016-17.



Staff Turnover

Non-medical staff turnover was 15% between 31 October 2016 and 31 October 2017.



NCISH questionnaire response rate

You have returned 98% of NCISH questionnaires between 2012 and 2017.

The figures give the range of results for mental health providers across England, based on the most recent available figures: 2013-2015 for suicides, homicides and sudden unexplained deaths (SUD), 2016-17 for people on the Care Programme Approach (CPA), 31 October 2016 to 31 October 2017 for non-medical staff turnover and 2012-17 for trust questionnaire response rates. 'X' marks the position

of your Trust. Rates have been rounded to the nearest 1 decimal place and percentages to whole percentage numbers.

2.1.3 Progress against 2017/18 initiatives for Priority 3 (patient experience) - people have a positive experience of their care and support

2.1.3.1 Roll out the Triangle of Care across our services

The roll out of the Triangle of Care work is continuing within the Trust and there have been some changes to the group leading this and some current vacancies which are to be filled.

In the last year we have gathered carer feedback from community services relating to carers and whether they are feeling that their role has been identified and valued. The response rate was very small and the audit has not, as yet, been repeated. Therefore until the audit is repeated there is no measure of improvement in place. The Carer Service Delivery Manager has identified a carer satisfaction questionnaire that was co-designed and which asks the questions of carers that we would like to introduce along with a methodology to roll it out. This will be taken to the next Care and Safety Planning and Recovery Group (CASPAR) meeting for support for this proposal.

We have been awarded the Stage 1 award for Triangle of Care in January this year. This was awarded on the basis that we will be resourcing the work for Stage 2 which will require identifying an operational lead. Stage 1 was awarded for our community services in the Leeds Care Group and stage 2 will be for every other service we provide by January 2020.

We will be rolling out a number of initiatives related to improving carer support in the next 12 months related to:

- Staff awareness training both e-learning and 'classroom based'
- Carers' Charter
- Resourced Staffnet
- Support around confidentiality and information sharing
- Carer/family pathway
- Carers information pack
- Carer satisfaction survey.

To deliver this across the Trust will require coordination and we are currently reviewing options for how this is best delivered. The Director of Nursing and Professions will be the executive lead for this work. The Patient Experience Manager is also providing some support for this.

2.1.3.2 Develop mechanisms to record service user and carer feedback and demonstrate that we have taken action to make changes based on that feedback. This will include the Friends and Family Test, as well as other feedback systems developed by the Trust

We gather feedback from service users and their carers through a broad range of methods including local and national surveys. Participation in the national community and inpatient surveys means that we can benchmark our performance in regard to service user experience on at least an annual basis with other mental health trusts. In the 2017 surveys, the Trust demonstrated that in almost every area of our work we have maintained our service levels or improved slightly.

In response to the comments our service users made, we developed pledges about what we will do to provide even better services which include:

- Making sure that our service users develop their care plan with their mental health and social care professionals and are given a hard copy with an agreed date to review it
- Investigating reasons for service users feeling unfairly treated while in hospital
- Taking further action to make service users feel safer while in hospital.

Other key mechanisms to obtain feedback include:

- ''You said, we did'' community meetings. The meetings are an opportunity for the people who use our services to give feedback and share ideas, alongside receiving timely responses about any issues of concerns.
- The Trust has a well-established Service User Network (SUN) This is a monthly meeting where service users and carers get together to share their experiences of Trust services, as well as providing a platform to support the shaping and influencing of service provision and development. This year will see a particular focus on 'hard to reach' and diverse communities. SUNRAYS has also been set up in locality areas to provide a similar platform to help extend our ability to reach a wider group of stakeholders and the team are working in partnership with other statutory, third-sector and voluntary organisations to help increase membership.
- We are working with Quality Health to identify where improvements are possible in terms of increasing the volume of our responses in the Friends and Family Test and are working with services and exploring a number of other options to improve feedback.
- The Trust recognises the importance of learning from complaints and the value of sharing this learning across the organisation. Complaints present an opportunity to review patient care, our services, and the way in which we interact and provide information for our service users. We have internal processes to capture complaints and compliments, but in addition to this we support the capture of external feedback through NHS Choices and Care Opinion. Complaint response letters include information on where action will be taken to put an unsatisfactory experience right. Often this may involve individual staff members reflecting on the way they have provided care, team discussions for wider group learning, staff training or use of the complaint as a case study for learning.

A key area for the Patient Experience and Involvement Team is to ensure that we have a fit for purpose engagement model. An external review will be undertaken which will influence and provide key improvement plans for future experience and involvement across the Trust, ensuring that collating and learning from feedback at the right time and in the right place becomes less of a challenge.

2.1.3.3 Implement a holistic approach to ensure that physical and mental health receive the same level of attention from staff

The relationship between physical and mental health is complex and poorly supported by the national healthcare design in its current form. In Leeds, over one third of people registered as having a Common Mental Health Disorder have one or more long term condition such as diabetes or Chronic Obstructive Pulmonary Disease (COPD). These poor health outcomes are largely attributable to preventable disease, particularly in people experiencing serious mental illness. Side effects of medication, lifestyle and difficulty accessing mainstream health services all contribute to the decreased life expectancy of many service users.

2.1.3.3.1 Progress in the last year

Physical Health Priorities: The appointment of a Physical Healthcare Lead has provided the opportunity to explore physical health provision in the Trust and identify key priorities for improvement. These are:

- Improving physical health monitoring of service users receiving medication known to have side effects which impact on physical health.
- Reviewing how we meet the general health needs of inpatient service users; e.g. how we refer into specialist services such as tissue viability, continence and urology services.
- Providing staff with the skills needed to support the physical health of service users.
- Working with the wider healthcare system to support service users when they access other organisations for their physical health needs.
- Supporting smoking cessation and maintenance of a smoke free status.

These five key areas have been agreed as the physical health priorities for the Trust. They have been identified on the basis of their ability to positively impact on quality and safety, and to capitalise on the progress towards new models of care being explored across the city.

CQUIN: Over the last year, the Trust has made progress towards achieving the milestones of the following CQUIN indicators:

CQUIN 3. Improving physical healthcare to reduce premature mortality in people with SMI.
CQUIN 9. Preventing Ill Health by Risky Behaviours - Alcohol and Tobacco.

Both of these indicators require us to develop relationships and work collaboratively with partners in primary care and the local stop smoking and alcohol and drug service providers. These areas of work will continue over the period of 2018-19, and it is anticipated that this will result in a better experience for service users and improved health outcomes.

2.1.3.4 Devise measures to support service users with housing and employment

"We agreed with our commissioners to the further roll out of the partnership vocational support model with Leeds Mind's 'Work Place Leeds' service within our Forensic and Assertive Outreach Services in addition to our CMHTs and Intensive Community services."

The partnership vocational support model aims to provide support to our service users to find work or to retain employment and has progressed with significant achievements, including:

- Co-location of ' Work Place Leeds' workers and identification of Trust Vocational Leads within all community service areas
- The delivery of information and awareness sessions to increase awareness of the support service within community teams
- Partnership event held with Work Place Leeds' employment workers and Trust vocational leads to develop partnership working and share best practice
- A 13% increase in the number of service users who have accessed the service, and a 22% increase in the number of service users who have secured paid employment, based on mid-year figures.

Table 13 – Service user support with housing and employment

Outcome Area	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Employment Support	Data not yet available					
Number accessed service	298	409	343	302	266	440
Secured paid employment	68	84	110	94	122	139
Accessed volunteer opportunities	82	74	48	84	100	75
Training	134	163	149	142	195	218
Job Retention Service	Data not yet available					
Number accessed service	79	120	153	138	177	178
Number who retained their jobs (3/6/9 months)	74	110	149	135	173	175

2.1.3.5 Implement the new learning disability model

A review of the Community Learning Disability Service commenced in May 2016 and the redesigned service was delivered in September 2017. The aim of the review was to deliver a community model that supports the national Transforming Care agenda. The review also looked at how the team worked and set out to standardise team processes and structures.

An evaluation of the new model was undertaken four months after going live. The key evaluation points included comparison with data drawn at the start of the review and qualitative feedback from teams as to whether issues which were identified had been/are being addressed by the new structure.

The evaluation looked at the following areas:

- Referrals – these have reduced as service criteria have been made clearer and referrers have been encouraged to consider mainstream services rather than specialist learning disability teams to meet service users' needs
- We manage service users' care in a consistent way at a higher level but this varies in the detail of the care provided.
- Feedback on the out of hours nursing service has been positive
- More clarity is needed on the use of the Care Programme Approach.

Overall, the new model has supported a seamless continuation of service for service users and has started to provide consistency for the work being picked up by community teams. The new model will need more time to bed in and fully develop and further evaluation will be needed.

Work with day services will be completed ahead of the agreed 12 month timescale and this will have a further positive impact for service users. The health facilitation team is building positive connections and building momentum with GPs and community mental health teams.

Further actions from the four month evaluation have been identified and will be progressed whilst our evaluation continues.

2.1.4 Priorities for 2018/2019

The identification of the priorities for 2018/19 has been based on the following principles:

- Priorities are based on recently approved strategic plans and inform our operational plan submission
- Responsiveness to known or expected commissioning intentions
- Whilst delivery of regulatory CQC requirements will be within business as usual assurance, any ongoing progress will be an action in its own right
- Use existing resources/personnel where possible and therefore align core activity to priorities
- Provide additional resource where necessary to enable delivery of the priority
- Align with overall financial planning including Cost Improvement Programme (CIP)

These priorities reflect the most significant and cross-cutting work programmes which will have executive leadership oversight to ensure delivery of service improvements in line with our overall Strategic Plan. The collective agreement is that these are essential programmes of work. There are likely to be additional programmes of work that the Executive Team agrees to prioritise in response to wider changes with the Sustainability and Transformation Partnership, Leeds Plan and commissioner intentions.

All the priorities identified are core to the work of care groups and corporate teams and additionally have been subject to review to ensure they can be adequately resourced. They will inform individual objective-setting as part of our appraisal process and be embedded with our performance oversight arrangements for care groups and corporate services and are aligned with the cross-cutting work in our strategic plans.

2.1.4.1 Defined Change Projects

- Commission, design and deployment of new Electronic Patient Record (will go beyond 2018/19)
- Community Mental Health Services redesign
- Decant of specified community premises
- Delivery of New Care Models
- Scoping of local rehabilitation model (likely Q3 and implementation into next year)

2.1.4.2 Cross cutting enablers

- Staff engagement, OD expertise, well-being and stress management, staff retention, management of change capacity
- Public Finance Initiative (PFI) resize and refinance
- St Mary's Hospital site decant
- Implementation of defined model for Quality Improvement
- Review of Patient Experience and delivery of improvements

2.1.4.3 Business as Usual

- Sustained improvements in bed capacity to reduce out of area placements and delayed transfers of care
- Development and delivery of the Winter Plan
- Refurbishment of inpatient PFI stock
- Safe staffing refresh
- Inpatient bed capacity modelling refresh

2.1.4.4 Mental health Collaborative and STP Work

- STP model for assessment and treatment in Learning Disability services
- Psychiatric Intensive Care Unit (PICU) model
- Specialist Rehabilitation Model
- Forensic model for West Yorkshire and Harrogate partnership area
- Primary care mental health model

2.1.4.5 Governance reporting on our priorities

We will provide a high-level assurance report to the Board on a bi-annual basis. This will have been presented to the various Board sub-committees for assurance and more detailed scrutiny. These bi-annual reports will encompass a mid-year and end of year review.

Operational governance structure will take account of some of the cross-cutting elements of some of the priorities (whereby different aspects may need to be reported to different groups within that operational structure). Terms of reference for each respective operational executive led group will be reviewed to ensure the appropriate membership and duties are in place to oversee the work and the delivery of our priorities.

Quarterly, the Programme Management Office will provide a report against key deliverables to the Senior Leadership Team by way of a progress report.

Linked with our priorities for delivery, we also intend to expand the breadth of our Quality Impact Assessment process and governance to assess the quality impact of any cost improvement/neutral schemes/tenders. Assurances on the outcome of this process will be reported to the Quality Committee.

Table 14 – How we will measure our three priority areas against our strategic plans in 2018/19

	Trust strategy strategic objectives	Strategic Plan	Strategic Plan objectives	Cross-cutting Quality Strategic Plan objectives
Priority 1	We deliver great care that is high quality and improves lives	Clinical Services Strategic Plan	▪ Supporting people in their recovery ▪ Supporting people to achieve their agreed goals and outcomes ▪ Supporting staff to promote and coordinate helpful and purposeful practice	▪ We will develop a clear implementation plan in order to deliver the Quality Strategic Plan in line with our agreed Trust priorities
Priority 2	We provide a rewarding and supportive place to work	Workforce & OD Strategic Plan	▪ Shaping a Positively Engaged and Healthy Workforce ▪ Developing High Performing Teams ▪ Developing Collective Leadership ▪ Recruiting, Retaining and developing Talent in the Workforce ▪ Delivering Innovation, Learning and Change ▪ Developing Behaviours to ensure Trust Values Live	▪ In addition to the Trust's quality priorities, each service will develop at least one local quality priority
Priority 3	We use our resources to deliver effective and sustainable services	Estates Strategic Plan	▪ We will consolidate and rationalise our estate ▪ We will optimise partner estate as part of the one public estate agenda ▪ We will optimise the use of technology linked with our agile working principles ▪ We will optimise building, design and layout	▪ We will develop a quality culture across the organisation and establish a process which enables services to identify the support they require and support they can offer to others when implementing our Quality Strategic Plan
		Health Informatics Strategic Plan	▪ We will deliver an EPR/EDM that makes the Trust an exemplar in Mental Health ▪ We will collaborate with our partners to provide integrated systems ▪ We will deliver mobile and network solutions that enable clinical and estates plans ▪ We will deliver technologies that streamline back-office services	

2.1.5 Additional quality information

2.1.5.1 Duty of Candour

The Trust completed the following actions to comply with Duty of Candour:

We have a robust process for our Serious Incidents (SI) investigations whereby contact is made with the families at the earliest opportunity, and first contact is initiated by the care team offering condolence and support. The second contact is a letter to the family from the Deputy Director of Nursing. This letter details the investigation process, a request for the family to contribute to the review and includes a formal apology.

When it has not been possible to identify the next of kin, we make contact with the Coroner's Office to assist in forwarding a letter on behalf of the Trust.

Throughout the SI process the SI investigator meets with families and, in addition, shares the findings of the reports we produce. The Trust attends the regional mortality meeting led by NHS Improvement and through this forum is working towards developing Duty of Candour guidance for all mortality reviews, not only those that are identified as Serious Incidents.

In September 2017 we developed a maturity matrix to identify our current position in relation to how we support bereaved families and friends. In September 2017 we were at 'Firm Progress' moving to 'Results Achieved' by March 2018.

We have a Duty of Candour policy due for review in April 2018 and a revised policy will incorporate all mortality.

During the period 2017/18, the Trust applied Duty of Candour to 464 reported incidents which is an increase from the number recorded in 2016/2017 of 299.

2.1.5.2 National Staff Survey

Each autumn we participate in the annual NHS Staff Survey. Table 15 below shows our performance in respect of response rate, and tables 16 and 17 show the top and bottom five ranking scores as presented in the findings.

Table 15 – Staff survey response rate

2017 survey		2016 survey		
Trust	**National average**	**Trust**	**National average**	**Trust movement between years**
56.3%	52%	53%	50%	+3.3%

We continued to adopt a full census approach to the survey in 2017. We transitioned more staff to completing the survey via the online method (approx. 55% in 2017, up from 24% in 2016). Paper surveys were still provided to those teams where accessing the survey online would present a barrier to participation.

We also maintained the approach taken in previous years to increase participation, which included a collation of dedicated staff and managers, including staff-side representatives, who come together to steer delivery of the survey and encourage participation by staff at a local level. This year's response rate increased to 56.3% and is 4% above the national average for all mental health and learning disability trusts in England.

The 2017 results show significant improvements in two local key areas compared to the 2017 scores: a reduction in the percentage of staff who have experienced physical violence from patients, relatives or the public in the last 12 months and staff feeling more supported by their immediate managers.

We are performing better than the national average for mental health and learning disability trusts in England across five key areas, four are related to improvements in staff health and wellbeing and the fifth is an improved indication of a positive reporting culture where more staff feel able to raise errors and incidents when they occur.

The 2017 Staff Survey results show that the Trust's ranking improved to position 13 out of the 25 mental health and learning disability trusts in England. This was an improvement from position 16 in 2016.

Following the results of the survey in 2016, we began specific programmes of work to address some of the key themes and areas for improvement, and the 2017 results show that staff are reporting improvements in those targeted areas. Some of the ways in which we have addressed staff's concerns include:

- Increasing the opportunity for staff to engage with senior leaders across the Trust and have input into strategy. We introduced initiatives such as Directors' 'Back to the Floor' visits which give staff at all levels direct access to our Directors. The continuation of listening events, such as Conversations with the Chief Executive also provide staff with opportunities to discuss concerns and raise issues directly with the Chief Executive and provide Board insight via a temperature check. Additionally, we held workshops with staff to engage with them in the development of the Workforce and Organisational Development Strategy.
- We also continued to focus on staff health and wellbeing. Following on from the introduction of the new Employee Assistance Programme in 2017, we held a series of health and wellbeing roadshows across the Trust, as well as the introduction a physical health check service and self-referral to our fast-track appointments for work related stress checks and support. Again, these types of initiatives have helped drive our staff survey satisfaction increases in these areas.

The tables below show the results from the 2017 staff survey; specifically the top five ranking scores. These show where we compare most favourably with other mental health and learning disability trusts in England.

Table 16 – Top five ranking scores

	Trust Score 2017	National Average* 2017	Positive difference against national average*
Percentage of staff attending work in the three months despite feeling unwell because they felt pressured to do so	49%	53%	-4%
Percentage of staff feeling unwell due to work related stress in the last 12 months	38%	42%	-4%
Percentage of staff working extra hours	69%	72%	-3%
Percentage of staff reporting most recent experience of harassment, bullying or abuse (higher scores indicate a positive reporting culture – higher score is better)	64%	61%	+3%
Percentage of staff reporting errors, near misses or incidents (higher scores indicate a positive reporting culture – higher score is better)	95%	93%	+2%

*national average for all mental health and learning disability trusts in England.

Table 17 – Bottom five ranking scores

	Trust Score 2017	National Average* 2017	Negative difference against national average*
Effective team working (the higher score out of 5, the better)	3.77	3.84	-0.7
Percentage of staff reporting most recent experience of physical violence (higher scores indicate a positive reporting culture – higher score is better)	90%	93%	-3.0%
Effective use of patient/service user feedback (the higher score out of 5, the better)	3.59	3.72	-0.13
Staff motivation at work (the higher score out of 5, the better)	3.82	3.91	-0.09
Fairness and effectiveness of procedures for reporting errors, near misses and incidents (the higher score out of 5, the better)	3.67	3.75	-0.08%

*national average for all mental health and learning disability trusts in England.

2.1.5.2.1 Addressing areas of concern

An analysis of our staff survey results provides us with a basis for determining the main areas to focus on when developing our key areas for action in 2018. The Trust will continue to use the *Your Voice Counts* crowd sourcing platform, as well as face- to-face listening events to engage with staff on strategic issues from the national staff survey key findings.

We have invested heavily in enhanced local team reporting for the 2017 Staff Survey results and are working with staff right across the Trust to deliver these results at a local level. Service area leaders will then work with their teams to identify three areas of improvement and local action plans will be developed to take this improvement work forward in 2018.

2.1.5.3 Safer Staffing

All hospitals are required to publish information about the number of Registered Nurses (RN) and Health Support Workers (HSW) on duty per shift on their inpatient wards. This initiative is part of the NHS response to the *Francis Report* which called for greater openness and transparency in the health service.

Full details of staffing levels are reported to public meetings of our Board and made accessible to the public via the UNIFY Report on the NHS Choices website. Safer staffing information is also accessible to the public via the Trust's own website.

In addition to this, the Trust is required to openly display information for service users and visitors in all of our wards that shows the planned and actual staffing available at the start of every shift.

From May 2018, all NHS trusts have been asked to report back monthly on their care hours per patient day (CHPPD) data to NHS Improvement, so that a national picture of how nursing staff are deployed can start to be built. This new data will allow the Trust to see how their CHPPD information relates to other trusts within a speciality and by ward, in order to identify how we improve our staff deployment and productivity for our benchmarked services.

Figure 6 – Care hours per patient day (CHPPD)

Care hours per patient day =	**Hours of registered nurses and midwives alongside Hours of healthcare support workers**
	Total number of inpatients

By collecting CHPPD information each month NHSI aims to see where unwarranted variation is happening and identify what good looks like. Having established this, examples of best practice can be identified and the principles of the highest performing trusts can be implemented across the country.

From April 2018, the Trust has established a Safer Staffing Steering Group which will oversee both the CAPPD and UNIFY information. The Trust has reformatted the UNIFY reports to incorporate the new requirements in advance of the deadline, to make sure that we are contributing to the national dataset and can use the information to benchmark our services accordingly.

The Safer Staffing Steering Group will report into the Quality Committee and Board through the Director of Nursing and Professions' monthly safer staffing paper, which also includes the Trust's use of regular bank staff and temporary staffing.

2.1.5.3.1 Nursing and Quality

Quality is a key requirement of all Board members in the organisation. From the Board to front line services and staff, there are a number of groups, forums and committees in place to drive up quality.

The Director of Nursing and Professions is accountable for Quality Assurance, The Medical Director for Quality Improvement and the Chief Operating Officer for Quality Governance.

In November 2017 a peer review process was introduced across all teams in the organisation. This is based on the Care Quality Commission's five Key Lines of Enquiry (KLoE). An annual rolling programme is in place where each team receives a peer review visit from a cross section of senior clinical and corporate staff, with a summary report of the peer review visit, with any actions being monitored via the services care group governance structure.

Back to the floor visits are in place for all Executive Directors and the Director of Nursing and Professions has carried out safer staffing visits to all inpatient areas during 2017/18.

2.1.5.4 Accreditation schemes, quality networks and Quality Improvement Programme

- Quality Network for Perinatal Mental Health Services (QNPMH)
- Quality Network for Eating Disorders (QED)
- ECT Accreditation Scheme (ECTAS)
- Psychiatric Liaison Accreditation Network (PLAN)
- Memory Services National Accreditation Programme (MSNAP)

POMH-UK

- 16b Rapid Tranquilisation (March to May)
- 18a Clozapine (June)
- 6d Side effects of depots (Sept and Oct)

In the current financial year (2017/18) the Trust undertook (or is currently undertaking) the following POMH-UK projects:

a) Topic 17a: The use of depot/long-acting injectable (LAI) antipsychotic medication for relapse prevention (national report received in January 2018 - results to be discussed at the next Medicines Optimisation Group (MOG) (April) and approved at the senior leadership team meeting in May.

b) Topic 15b: Prescribing valproate for bipolar disorder (still waiting results/report from the National Team – scheduled for the end of April 2018).

c) Topic 16b: Rapid tranquillisation (data collection started in March 2018 – deadline: 31/05/2018).

2.1.5.5 Trust Continuous Improvement (CI) Team

The CI Team is based on the management corridor at The Mount and consists of a CI Lead, 2 CI Advisors and a CI Project Support Officer. The team works with clinical and corporate teams to transform good ideas into sustainable workable solutions designed to improve and deliver quality for everyone using our services.

As a resource the team can be accessed by all staff across the Trust, this can be via an informal conversation or a formal request for support. Either way, the approach used by the CI Team is to provide the space, time, tools and support to teams and individuals, as we know that staff have the ideas and the solutions for improvement.

2.1.5.5.1 CI Team Activity

The CI Team has supported a wide range of departments from corporate teams such as Estates and Human Resources to ward based and community based teams. Since January 2017, the CI team has supported a total of 23 improvement projects and activities across the organisation. Below are three examples:

Example 1
The Younger People with Dementia (YPWD) service contacted the CI team to ask for support in streamlining their referral management processes. Staff feedback to senior management suggested the service felt that parts of the referrals process were inefficient, time consuming and prone to errors. Specialist process improvement skills were required to harness the team's enthusiasm.

As a first step the CI team worked with the service to produce a process map for the referral management procedure, providing a detailed view of each process step. Following on from this work, a series of 'activity follows' were performed which provided the team with a quantifiable view of the effort required to manage the referral process. This identified blockages, issues and barriers for the process to operate smoothly. Additional information was gathered from COGNOS to support this work.

Below is a brief summary of the findings.

Referral Quality: 40% of referrals received did not contain all the service user information that clinicians required to be able to offer an Initial Assessment Appointment. Handling poor quality referral information consumed six hours of staff time per week and resulted in service users' referrals being 'postponed' for an average of 35 days until all the correct information was gathered.

Service Inconsistencies: mechanisms for communicating with referrers were processed on a case by case basis. Individualised responses were provided to referrers, consuming 2.5 hours of staff time per week. The timeliness of service communications was sporadic and an average of nine days to process replies was recorded, detrimentally impacting the service's ability to meet key performance indicators.

Stakeholder Awareness: stakeholders did not have a good understanding of the scope of the service and the referral quality requirements. In an Away Day setting, the CI team presented the Process Map to the service and facilitated process improvement discussions. Discussions were recorded, themed and a number of action plans were created:

Referral Quality: to create an YPWD referral form and a service inclusion/exclusion criteria document.

Standardised Responses: to create standard service responses to all common occurrences.

Stakeholder awareness: to develop and deploy a marketing and communications strategy. Process improvement work streams were managed through weekly improvement huddles. The creation of the service's improvement products were managed collaboratively, with CI Team providing oversight and support.

Following a four month pilot period a summary of the impact of the improvement products is:

Referral Quality: referrers provided the YPWD team with correct complement of service user information within 23 days, the referral form and standardised letter response - this resulted in a 12 day improvement.

Standardised responses: activity performed following the integration of improvement products (standard letter templates) reduced the referral management effort from 6 hours to 2 hours per week.

Stakeholder awareness: the Memory Services webpage experienced a 52% increase in page visits during the pilot. Positive feedback was received from referrers during engagement events. The service experienced a 14% improvement in referrals being submitted with the correct information from the outset. An End of Project report is scheduled for release in June 2018, providing sufficient time for the true impact of the improvement interventions to be available.

Example 2
The Head of Serious Incident Administration asked the CI Team to support a piece of work which was aiming to improve the reporting of Serious Incidents (SIs)in the organisation. Adhering to nationally mandated (NHS England) reporting guidelines for SIs was proving challenging for a variety of reasons. Facilitation and process mapping expertise was requested to map current and future state of reporting SIs.

Stakeholders involved in the reporting of serious incidents were identified and invited to attend an away day. During the away day, the current state was mapped and reviewed, enabling issues/challenges to surface for detailed community discussions. The second phase of the day involved working in teams to map a proposed future state, taking into consideration mitigating actions or interventions to overcome the issues/challenges with the current process.

The SI team had gained an invaluable insight into the challenges faced by all involved in the reporting of SIs and gathered the intelligence required to deploy a revised SI reporting model informed by those integral to the process.

Example 3
The Leeds Autism Diagnostic Service (LADS) was commissioned in 2013 to serve a maximum of 16 service users per month. During 2017, the service received an average of 32 referrals per month, with the highest month recorded being October at 48 referrals. The steady increase in referral numbers had correlated with a decrease in key performance indicator (KPI) performance. Whilst KPI compliance is good at 12 weeks (92%) and 26 week (62%) the service is keen to explore efficiency opportunities in the pathway to make further improvements.

The CI Team's task was to work with members of the service to identify efficiency opportunities within their referral pathway - to create staff capacity and improve KPI compliance.

This project is work in progress. It began in February 2018 and a a process map of the current state has been produced which is currently under review by the service. A team away day was held in late March.

2.1.5.5.2 CI Team Wider Connections

Whilst the CI Team has supported a wide range of departments across the Trust, it is also actively involved in the wider CI community both locally and nationally. Team members have recently spoken at the UK Visas and Immigration National Improvement event in Liverpool about CI in the NHS and have built strong relationships with the following:

The Health Foundation – an independent charity committed to bringing about better health and health care for people in the UK

Institute for Continuous Improvement in Public Services (ICiPS) – a charity working to 'embed continuous improvement in the delivery of public services through education.' To this end, ICiPS is a catalyst for the creation, collation, and dissemination of information that supports the creation of continuous improvement cultures.

Yorkshire and Humber Improvement Academy – a team of improvement scientists, patient safety experts and clinicians who are committed to working with frontline services, patients and the public to deliver real and lasting change for the people of our region.

Leeds Institute for Quality Healthcare – a partnership initiative between the University of Leeds, the NHS Leeds Clinical Commissioning Group, Leeds City Council and the three NHS Trusts in Leeds which has developed a system-wide approach to leadership and quality, using data analysis and improvement techniques to make changes in partnership with patients, careers and families.

Institute for Healthcare Improvement – an independent not-for-profit organisation based in Cambridge, Massachusetts, which is a leading innovator, convener, partner, and driver of results in health and health care improvement worldwide.

NHS Improvement – responsible for overseeing Foundation Trusts and NHS trusts, as well as independent providers that provide NHS funded care. Its priority is to offer support to providers and local health systems to help them improve.

What is next for the Continuous Improvement Team - While the team will continue to give tailored support to individuals and teams based on their needs, the CI Team is in the process of developing a plan to support the delivery of the Trust's Quality Strategic Plan. The CI plan is based on the recommendations within the White Paper from the Institute for Healthcare Improvement called '*A Framework for Safe, Reliable and Effective Care*' January 2017.

The maturity matrix within this framework was applied to the Trust. The assessment concluded the organisation was 'just at the beginning' of the improvement journey.

2.1.5.6 Freedom to Speak Up Guardian

In October 2017 we appointed our new Freedom to Speak Up Guardian (FTSUG). This role has been allocated 2 days per week which allows sufficient time to carry out the duties required of the Guardian.

To continue to raise awareness of the role and the process for raising concerns, the Guardian has undertaken a communication strategy which included meeting with staff in services, and at the staff induction as well as distributing flyers and posters across the organisation. The process for raising concerns was audited in March 2018 and was given a rating of significant assurance. There were some actions identified to strengthen parts of the process which have been accepted and an action plan drawn up.

In 2017/18 there were a total of 34 individual concerns raised to the FTSUG up to and including 31 March 2018. The themes from these concerns have been:

- 17 relationship issues
- 6 process issues where policies and procedures were not followed
- 3 patient safety issues (that are now resolved)

2.1.5.7 Actions to promote and improve equality, diversity and inclusion for Black and Minority Ethnic (BME) service users

We have completed research work in partnership with Touchstone to review relevant literature and data to improve understanding of the experience of crisis care pathways by BME communities in Leeds, and to support care development work. Findings and recommendations have been shared and engagement undertaken internally with staff and stakeholders at an event held in December 2017. Development and improvement actions have been identified through this process to be implemented from 2018/19.

Partnership work at citywide level has also been undertaken as it is recognised that improvements within both primary and secondary care support structures are required to address the entrenched inequalities within mental health which currently exist. This includes work with commissioners, local

authority and the third sector to identify citywide priority areas for action identified through a stakeholder event held in November 2017. Actions will be implemented from 2018/19 and progress reported through the city-wide Mental Health Partnership Board.

Staff training and development work has been undertaken to increase their knowledge and skills in effectively supporting service users from BME communities. This includes a Diversity and Inclusion development day attended by over 150 staff held in November 2017. This comprised of a series of workshops delivered by internal and third sector knowledge experts. Workshop areas included refugees and asylum seeker, Roma communities and BME communities. Further information is available via the web link below:

https://www.touchstonesupport.org.uk/2017/12/report-access-and-experience-of-mental-health-crisis-care-services-in-leeds-by-black-and-minority-ethnic-communities/

2.2 STATEMENT OF ASSURANCE FROM THE BOARD

The following sections (2.2.1 to 2.2.10) provide assurance on the services provided by the Trust.

2.2.1 Health services

During 2017/18, the Trust provided and / or sub-contracted five relevant health services. These are:

- Learning disability
- Adult mental illness
- Forensic psychiatry
- Old age psychiatry
- Child and adolescent psychiatry.

The Trust has reviewed all the data available on the quality of care in five of these relevant health services.

Below is a list of the specialist services that the Trust provides:

- Forensic services
- Child and Adolescent Mental Health Services (CAMHS) Tier 4 inpatient services
- Eating disorders services
- Gender identity services
- Liaison Psychiatry
- National Deaf Children and Families Service
- Northern School of Child and Adolescent Psychotherapy (NSCAP) clinical services
- Perinatal services
- Personality Disorder Service.

The income generated by the relevant health services reviewed in 2017/18 represents 100% of the total income generated from the provision of relevant health services by the Trust for 2017/18.

2.2.2 Participation in clinical audits and national confidential enquiries

During 2017/18, six national clinical audits and one national confidential enquiry covered relevant health services that the Trust provides.

- The learning disabilities mortality review (LeDeR) programme
- National audit of psychosis (NCAP)
- Prescribing observatory for mental health, UK (POMH-UK) – topic 17a the use of depot/long-acting injectable (LAI) antipsychotic medication for relapse prevention
- POMH-UK - topic 15b prescribing for bipolar disorder (use of sodium valproate)
- POMH-UK – topic 16b rapid tranquillisation

- National mental health commissioning for quality and innovation (CQUIN) Indicator 3a – cardio-metabolic screening
- CQUIN – Indicator 3b: collaboration with primary care clinicians.

Table 18 shows the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of the audit or enquiry. Not all of these projects had reached the point of producing and disseminating reports during 2017/18.

- The use of depot/long-acting injectable (LAI) antipsychotic medication for relapse prevention - the national report received in January 2018 and the results will be discussed at the Medicine Optimisation Group in April 2018 and approved at the senior team meeting in May.
- Prescribing valproate for bipolar disorder – the report is scheduled for publication at the end of April 2018.
- Rapid tranquillisation - data collection started in March 2018.

Table 18 – Number of cases submitted

National audit/Confidential Enquiry	Case required	Cases submitted
LeDeR	Not set number required	12
National clinical audit of psychosis	100	100% of those required
Topic 17a The use of depot/long-acting injectable (LAI) antipsychotic medication for relapse prevention	Not set number required	79
Topic 15b Prescribing for bipolar disorder (use of sodium valproate)	Not set number required	21
Topic 16b rapid tranquillisation	Not set number required	Data collection in progress
CQUIN Indicator 3a – Cardio-metabolic screening	100	100% of the those required
CQUIN – Indicator 3b: Collaboration with primary care clinicians	Not set number required	38

Table 19 provides information on projects that were completed during 2017/18. A number of the projects in the table started in 2016/17 and therefore do not appear on Table 19.

The reports of four national clinical audits were reviewed by the provider in 2017/18 and the Trust intends to take the following actions to improve the quality of healthcare provided.

Table 19 – Information about national audit findings

Project number (cycle) and title	What are we going to do?
POMH-UK Topic 01 &03 (1) Prescribing high-dose and combination antipsychotics on adult acute, intensive care and forensic wards	*To improve documentation of rational and plan for HDAT*: a. HDAT alert will be added to Electronic Prescribing and Medicines Administration (EPMA) by pharmacy which will alert prescribers and pharmacy. To be decided at the EPMA Group; b. To consider adding column on visual control board to highlight HDAT. Include assessment for extrapyramidal side effects on HDAT monitoring chart (to be discussed at the inpatient CIF meeting); c. HDAT monitoring sheets need to be kept in place where they

Project number (cycle) and title	What are we going to do?
	are kept up to date and reviewed. *To reduce amount of HDAT prescriptions*: A new rapid tranquilisation policy which promotes prescribing of stat rather than prn doses
POMH-UK topic 7 (5) Monitoring of patients prescribed lithium	• To improve monitoring of clinical practice and alert of any missing information. Await Neptune roll out and recheck with next audit. CCG will feedback results of Lithium reports to MOG. MOG chair to ask CCG 6 monthly. • To improve documentation of baseline test and long term monitoring. Trust to focus on initiation tests and implement baseline alert on EPMA and alternative way for community teams (paper or poster).
POMH-UK Topic 11 (2) Antipsychotics for people with dementia	• To improve documentation of potential risks and benefits of antipsychotic medication by the clinical team, prior to initiation. • To improve discussion with the service user and/or carer(s) for potential risks and benefits of antipsychotic medication, prior to initiation. • To improve review of medication and document the outcome in the clinical records. The medication review should also take account of possible adverse effects. All the recommendations are covered by other Trusts' action plans and no local action plan is required
CQUIN – Indicator 3b: Collaboration with primary care clinicians	The findings of this audit will be communicated to both of the Care Group Clinical Governance meetings as well as the Care and Safety Planning and Recovery (CASPAR) group where recommendations and actions will be discussed.

The reports and action plans of 52 local clinical audits were reviewed by the provider in 2017/18 and the Trust intends to take the following actions (Table 20) to improve the quality of healthcare provided.

Table 20 - Local audit findings review

Project number (cycle) and title	What are we going to do?
0054 (8) Trustwide record keeping	• The electronic tool automatically generated results for each consultant (community) and ward/team (inpatient) during the data collection. This will help to identify immediately areas of low compliance. b) Results for team/ward should be disseminated and discussed at the most appropriate meeting. • 10 golden rules of record keeping were published and disseminated across the Trust. This is a quick reference to help improve our record keeping standards. It's not exhaustive, but should help us keep the most important things in mind during busy shifts when we're always under pressure.
0191 (1) Triangle of Care	• Local reports to be given to teams alongside list of PARIS identities that may need updating. Local teams to devise and agree local actions: • Team training started within community teams.
0241 (1) Mental Health Act detentions	Based on the findings of this cycle of audit, and building on the actions implemented following the first cycle, the following recommendations have been agreed: • Continue with the monthly monitoring of the caseloads of each member of the Mental Health Legislation (MHL) Team

Project number (cycle) and title	What are we going to do?
	• Produce an annual report that uses the data generated by the monthly monitoring to provide assurance to the Trust • No further cycles of audit to be undertake unless the monthly monitoring highlights concerns
0250 (1) Trustwide documentation of Lithium and clinical correspondence to GPs	• Stronger collaborative approach between clinicians, pharmacy and other members of the multi-disciplinary team are required in order to make significant changes to the current standard of practice. • Results were discussed to relevant meetings and disseminated via emails to all consultants involved in the audit • Each locality developed an action plan looking at their own findings
0433 (1) Section 132	• To monitor the frequency with which section 132 information is provided to detained/Community Treatment Order (CTO) patients; • To improve the recording of section 132 information on PARIS; • To remind staff of the section 132 requirements and their responsibilities.
0400 (1) Qualitative impact of the 4C's of good record keeping	• To improve awareness of the importance of record keeping. The pilot sites to share individual findings in the care group's clinical improvement forums. • Agree educational record keeping programme. Record keeping programme should be developed and made available on iLearn.
0041 (1) Modified Early Warning Score (MEWS)	• The Trust's resuscitation and physical health emergencies procedure contains the guidance for undertaking MEWS and specified the training requirements relating to this. The resuscitation team are authors of this guidance and were consulted on the content of the audit. The results have been shared with the team for their consideration in relation to the following: o The redesign and launch of the Trust MEW booklet o Incorporation of findings into training that is currently available. The findings should also be considered in the context of reviewing the physical skills of our workforce and how this should be addressed through future training and education programmes. • The development of a system to regularly audit MEWS compliance across the Trust is a requirement of Care Quality Commission key line of enquiry S2.6 (u). It is proposed that this audit tool be used to inform a locally adapted version with real time feedback for staff to facilitate service improvement.
0003 (2) Electronic record keeping in the Pathway Development Service (PDS)	• To provide positive feedback to staff about areas of improvement in note keeping. • To work on improving areas of deterioration and ongoing poor compliance identified in the audit and work to standardise practice across the team.
0065 (1) Monitoring physical health consequences of clozapine: SSE Locality	• To improve staff awareness about the physical health requirements of their patients • To improve physical health monitoring at Clozaril Patient Management Service (CPMS) Clinic • To spend time educating the staff entrusted with running the clozapine monitoring clinic • To request for more resources (staff) provided to delegate responsibility to other staff members in the Intensive Community Services (ICS)or CMHT • To present a business case that will suggest starting a Physical health clinic that will run parallel to the CPMS clinic at Aire Court • To arrange meetings with clinical leads, consultants and Associate practitioner to discuss the ability of staffing a full stand-alone clinic with

Project number (cycle) and title	What are we going to do?
	named medic cover and nursing staff
0036 (3) Consent to medical treatment in forensic psychiatry inpatient service in York	Raise awareness of and implement local standards as follows: • T2 reviews need documenting in the notes • Admissions not to be when RC on leave • Those within three month rule should have capacity assessed and documented • T2 and T3 forms should be checked regularly.
0073 (3) Audit of Management of Really Sick Patients under 18 with Anorexia Nervosa (MARSIPAN) assessment guidelines in Inpatient CAMHS	• The medical and nursing staff are to ensure that the risk assessment pro-forma is being used on the unit. • Addition of a simplified guide for rating of risk using a traffic light system for risk assessment to encourage the use of the proforma.
0084 (2) Chronic pain pathway	• To improve coding of patient feedback on discharge from liaison psychiatry by requesting admin to add a box on the feedback form for clinicians to complete stating which pathway the patient is on. • To improve discussion at the multi-disciplinary team of patients who have attended clinic for more than the recommended number of sessions by prioritising discussions about them at the clinical case meeting once a month. • To improve clinicians' completion of the pathway data collection form for all patients on a pathway to include reason for drop-out. All clinicians will be reminded to complete the form after first contact.
0088 (1) Acute Liaison Psychiatry Service (ALPS) record keeping	• To ensure that all current staff are aware of the minimum expected information to be completed by each staff member following a psychiatric assessment of a patient. The auditor will develop a short guide on the expectation of documentation to be completed following each assessment. This information will be fed-back in the team meeting. • To educate new staff on the record keeping standards expected. All new staff (including bank staff) will be trained and updated on the minimum standard of the team's paperwork.
0088 (2) ALPS record keeping	• To ensure that all current staff are aware of the minimum expected information to be completed by each staff member following a psychiatric assessment of a patient. The auditor will develop a short guide on the expectation of documentation to be completed following each assessment. This information will be fed-back in the team meeting. • To educate new staff on the record keeping standards expected. All new staff (including bank staff) will be trained and updated on the minimum standard of the team's paperwork.
0102 (1) Audit of discharge letters from the West Leeds Intensive Community Service	• Modify the discharge letter slightly with a note regarding Amber Drug monitoring, changing the wording that will make it clearer that the discharge medications require filling up; • Tidying up the doctor's folders to have one to two copies of the standard forms for discharge letters, ensuring that there are boxes or space for Patient Reported Outcome Measures (PROMs) and outcomes to be filled in; • Write a handover document for junior doctors.

Project number (cycle) and title	What are we going to do?
0116 (1) The assessment of cardiac status before prescribing acetyl cholinesterase Inhibitors for dementia	• Disseminate results and recommendation of the audit to the memory service locally and at the audit meeting. • To make accessible of Yorkshire and Humber Clinical Networks guideline “The assessment Cardiac Status before prescribing Acetyl Cholinesterase Inhibitors for dementia” especially the “Rowland algorithm”. • Core trainee and Higher Trainee should be made aware of the guideline during their local induction in OPS post.
0117 (1) Physical health monitoring of patients on clozapine	• Introduce a template for physical health monitoring in the clozapine clinic/physical health clinic which may help to improve compliance and completion of recommended monitoring. • An alert system on PARIS may help to further facilitate this by prompting healthcare professionals to review their last physical health monitoring results and review when they require further monitoring. • Ensure that all healthcare professionals should have access to, and utilise, Leeds Care Records so that recent results can be reviewed to prevent unnecessary retesting. • Healthcare professionals must be able to identify abnormal BP/weight/heart rate and escalate this appropriately. Further education/guidelines may be required in this area to improve patient safety. • Subsection on PARIS labelled ‘test results’ to ease identification of salient results and improve workload efficiency by reducing time spent searching through sections of PARIS. • Consider performing either an HbA1c or random glucose in patients that are unlikely to have truly fasted for their blood tests.
0126 (1) Monitoring of dementia patients on antipsychotics in Memory Services and WNW CMHTs	• To standardise documentation of parameters across systems available within the Trust: a standardised page on PARIS must be developed in order to document the relevant physical health parameters. • To improve baseline recording and monitoring of physical health parameters. • To ensure all health care staff are aware of Lester guidelines.
0131 (1) An audit into the standard of clinical formulation at South South East Intensive Community Service (SSE ICS)	• Adopt a model of formulation that can be edited, that is standardised across the other ICS locations, that has some guidance attached for those members of staff that lack experience in the process and has evidence of efficacy. • To introduce re-formulation to our practice that the audit shows we are not doing at all.
0132 (1) audit of regular psychiatry review in Learning Disability	• To improve communication between medics and administration staff to make sure that all patients’ appointments are notified and recorded: • Re-appointment process can be done through the outpatients list being handed to the respective doctors seeing patients in outpatients with the doctor recording in front of the patient’s name if they attended, did not attend or cancelled. The time period the next appointment should also be booked for e.g. 4/12, 3/12 at this time, or, if required to be seen early, to note that period and forward all information to the administration staff to confirm the bookings • To ensure continuity of care is provided to the patients via organisation of six monthly meeting between medics and administration staff to go through the outpatients lists so that service users are not being missed

Project number (cycle) and title	What are we going to do?
0137 (1) Audit of CORE forms in Cognitive Behavioural Therapy (CBT) at Southfield House	• Provide more staff training about the role of CORE measure in CBT in particular CORE-OM • Assessing clinician and junior doctor to discuss the use of CORE-OM during CBT sessions with the patient to improve adherence. • Use deteriorating CORE – OM as a prompt or discussion with the client about area of improvement within therapy • Discuss the on-call findings in the CBT meeting and identify any further outcome measure that might be beneficial to implement in day to day practice.
0150 (2) Audit of compliance with Trust Venous Thromboembolism VTE prophylaxis guidelines	Findings were presented at the Acute Adult CIF in November 2017. It was agreed that no actions or future cycles of audit were necessary, as having VTE as a mandatory section on EPMA has resulted in sustained good compliance for VTE screening on admission.
0150 (3) Audit of compliance with Trust VTE prophylaxis guidelines	Findings were presented at the Acute Adult CIF in November 2017. It was agree that no actions or future cycles of audit were necessary, as having VTE as a mandatory section on EPMA has resulted in sustained good compliance for VTE screening on admission.
0156 (2) Older People's medical record keeping audit (West North West)	• Ensure senior doctors in WNW sector are aware of and have read Trust record keeping standards • To improve documenting of the following standards: o Time (standard 2); o Service user consent to disclose information (standard 8)
0179 (1) The assessment of capacity or competence on young people in an inpatient child and adolescent psychiatry unit.	• Depending on age, all patients should have a clear assessment of their capacity or competence • Within one week of admission which will be discussed at MDT (including medical and non-medical staff) and reviewed weekly. • An email is to be sent to doctors on the unit with the template attached. This assessment should be clearly documented in the MDT document for each patient with a name, date and reference to a corresponding PARIS entry. This is to be reviewed at each MDT meeting (weekly).
0194 (1) ESREP audit	• To improve monitoring of pulse at initiation and titration of treatment for those patients who are prescribed acetylcholinesterase inhibitors • To improve overall discussion and documentation during the initial diagnostic appointment (i.e. advice in driving status, attendance allowance and power of attorney)
0202 (2) Audit of assessment and treatment of low bone density in patients with eating disorders at Yorkshire Centre for Eating Disorders(YCED)	• To update the YCED triage assessment form and YCED inpatient multi-disciplinary team (MDT) assessment form to include the following risk factors: a) Gender; b) BMI; c) age of menarche; d) history of amenorrhoea; e) smoking; f) alcohol misuse/dependence; g) history of excessive exercise; h) co-morbid physical illness • To edit the YCED MDT review checklist to ensure that the communication of bone scan results to service users occurs promptly and consistent advice and recommendations are given • Explore the process of requesting bone scans as part of the upcoming inpatient process mapping work
0206 (1) Driving status of forensic outreach team (FOT) outpatients	Alternative monitoring is now in place – the dynamic HCR form, updated monthly, now has a specific prompt for driving.

Project number (cycle) and title	What are we going to do?
0211 (1) General health monitoring for patients taking clozapine	• To improve collection of annual physical health monitoring data for patients taking clozapine • To improve communication with GPs when monitoring duties are to be shared between secondary mental health services. • To formulate a standardised Trust-wide protocol for collection of annual physical health monitoring data for patients taking clozapine that would inform the practice of all clozapine services in the Trust by discussing with relevant committees/clinicians and leads • To formulate a standardised Trust-wide data collection tool for recording this data that is accessible to all clinicians, preferably across sectors • Disseminate and present report to involved clinicians and committees • To create and circulate a standardised letter template
0212 (1) Audit of reviewing bloods on admission	To carry on using the PIPA system already in place in both wards, and to continue providing information during the initial induction when new doctors join the ward (information such as documentation practice, how the ward works and the requirement for Electrocardiogram (ECGs) and PTs to be performed should be provided).
0221 (1) Monitoring of cardio metabolic risks in line with amber guidance in patient's staring anti-psychotic medications by ICS	• To feedback findings of audit to ICS East North East (ENE) • At the point of referral, consideration needs to be made as to how soon medication is likely to be commenced. At this point, it is worth considering whether physical monitoring will be required and as such, whether staff assigned to the initial assessment are capable of completing this, if it appropriate. • To develop new electronic care plan this will record the physical health monitoring of patients: • An easily accessible electronic record of required physical health monitoring should be created in an agreed area of PARIS and actioned by appropriate members of the team when items are completed. This should also be used when there is refusal of the monitoring by a patient or when it is not appropriate to be completed (along with documented reasons as to why). • The electronic record should be made available to the GP on discharge from the service by way of letter or fax
0228 (1) An audit of prolactin monitoring on antipsychotics	• To educate doctors in the team about prolactin levels by verbal feedback of results and email distribution of current guidelines.
0232 (1) Medicines reconciliation of non-prescribed medicines on admission to hospital	• To increase medicines reconciliation within 24 hours: results to be raised / highlighted with pharmacy staff and medical staff; • To increase compliance with enquiry about over the counter (OTC) / complementary medicines on admission: • 'Clerking guide' for junior doctors to include enquiry about non-prescribed medication; • Results to be highlighted within whole team through staff meeting and minutes and individual emails; • to discuss the possibility to amend the Trust medicines reconciliation form to include a tick box about OTC / non-prescribed medication.
0233 (1) Physical examination audit in Becklin Centre	• Raise awareness of good practice and discuss areas for improvement. Present the findings of this audit at a local meeting • Enable/continue to support best practice. Make sure that paper copies of the physical examination pro forma are printed off and placed in the junior doctors' on-call room for easy accessibility. In the meantime, work on developing an electronic version of the pro forma that can be

Project number (cycle) and title	What are we going to do?
	accessed from any computer in the Trust and put on PARIS. • Circulate email raising awareness that proformas are available: audit lead to speak to the Associate Medical Director about sending an email to all junior doctors in the Trust about completion of physical examination proformas, and the fact that some will now be located in the on call room.
0236 (1) Time to treatment for dementia following referral with memory problems	• To improve documentation of records - some records were difficult to find specific data such as date of scan request. • To improve communication with the CT scan department. This has already been put in place. The requests are made via secure email to negate the problem of lost/in actioned referrals.
0239 (2) Management of pregnancy and women's health in psychiatric settings (CMHT SSE)	• The results of this audit should be circulated once again to medical staff within South CMHT highlighting the poor concordance with NICE guideline CG192 and risks to patients, • Clinical supervisors within South CMHT should follow the guidelines themselves and provide their juniors with guidance about the importance of discussing contraception and family planning with female patients of childbearing potential. • Discuss introducing a mandatory section on PARIS to discuss contraception/pregnancy status for women of child bearing age. • Audit findings should be fed back to the Trust pharmacy department.
0253 (1) ESREP - CPA	• A checklist for completing documentation and clinical action could be designed, tested and evaluated in future research, to aid with the completion of all relevant areas documentation and clinical practice. • A service evaluation of service user views of their involvement and understanding of the CPA, and their perceived input into the creation of their care plans, would help supplement knowledge gained from this audit, and add an extra perspective, as clinical documentation may not always match clinical practice • A review of the current literature provided to service users starting on the CPA is indicated, perhaps with an evaluation of service user opinion. This is important as good information provision here, in conjunction with an effort to consistently provide effective discussions with service users prior to CPA meetings, could increase involvement, understanding and satisfaction
0256 (1) Audit of clinical process for section 136 assessment and management	• To increase awareness within the CAS team and assessors (including CAS staff – AMHPs and doctors), S136 co-ordinators and the junior doctors who participate in OOHs s136 work. • Offering more training around completion of the form (which is in the process of being amended in light of pending legal changes to s136), presenting the audit findings to the team and ensuring all new starters are aware from the time of induction. It is hoped that data collection will become more complete in subsequent years. It is clear from the audit that both s136 staff and the police will play a role in improving completeness of data collection. • Through individual supervision (via senior doctors and band 7s) staff can be encouraged to complete the form with particular emphasis on the areas which fall most short – prompting the Police to complete their part, completion of signed care plan, property recorded and signed for and reasons for Police departing.

Project number (cycle) and title	What are we going to do?
0257 (1) Clozapine interface communications across Leeds	• Develop links with relevant CCGs/GPs • Utilise mental health tab on LCR • Nominated MMT for each locality to deal with clozapine/depot prescriptions • Develop a system with primary care that address these issues e.g. send a fax of the clozapine prescription (once signed by a doctor and clinically checked by a pharmacist) to the CCG technicians, to ensure the patient data is updated accordingly.
0260 (1) Observation Audit - Wards 5 Becklin Centre	• To educate staff on best practise regarding observation. This requires the development of observation training, to be delivered to inpatient services to support staff in making and documenting decisions on prescribing initial levels of observation. • Other actions included informing Trust policy review, sharing findings to raise awareness of current and best practice and to complete interim monitoring exercise prior to re-audit.
0268 (1) FACE risk assessments audit	• Improve risk management plans • Collaborative risk assessments with service users • Improve carer involvement
0269 (1) Availability of physical health monitoring equipment in the inpatient setting	• Junior doctors should inform CTMs if they find an item missing as they are the staff members most likely to notice equipment running low on stock or missing. • Junior doctors to return items to clinic room of the ward once used. Lastly, it was recommended that wards need to regularly check the presence of equipment.
0270 (1) Audit on the time from referral to treatment in patients diagnosed with dementia (CMHT WNW Locality)	• To improve timely access to high quality assessment and treatment as it is essential for patients with suspected dementia • To improve documentation of reasons of non-compliance with agreed timeframes for contact, assessment and treatment. To develop standards for documentation in such cases • To improve knowledge of model for memory services citywide as there is anecdotal feedback to suggest there is variation across the city. A suggestion of a similar audit to be completed in other memory services teams to enable system-wide learning. • To disseminate findings and discuss having internal changes to the pathway with the aim of releasing clinical time within the memory service to facilitate the provision of earlier appointments. • Inform chair of the relevant Clinical Improvement Forum (CIF) and ask her to table the report for discussion at the CIF meeting and present recommendations. • To inform and discuss with the chair of the relevant Clinical Improvement Forum who can then look into the recommendations.
0273 (1) Risk Assessment in NDCAMHS	• SR to discuss learning points with NDCAMHS team members and discuss learning points/recommendations for changes to practice. This aims to identify barriers to current practice for documentation of risk through discussion with the team. • Audit to be discussed with NDCAMHS team with regard to consideration of development of alternative risk pro forma, if appropriate. • Team to document decisions regarding referral to local CAMHS on the young person's discharge letter, stating whether a referral to local CAMHS was made and why this was appropriate or not. This aims to improve the recording of when a local CAMHS referral was, or was not, necessary. This will be encouraged by updating the letter writing standards to include it.

Project number (cycle) and title	What are we going to do?
0277 (1) Audit of transition protocol for national deaf CAMHS	• To review audit standards as a team in the service away day, with particular reference to NICE guidance. • To reinforce good practice and agree together the best way to ensure that we focus on co-collaborating for deaf awareness/communication profiles. • To share the audit with colleagues in adult mental health via email and discussion.
0278 (1) Use of consent to treatment forms on acute working age adult wards	• Raise awareness of processes re consent forms by disseminating results and audit report to pharmacy lead and acute inpatient matron, as well as to the consultants of the involved wards for cascading to other staff in their teams. • Findings and recommendations were also presented at a doctors' monthly teaching. • The audit lead met with the MHA office, who will disseminate the findings at the Trust SIFF meeting and the legislation steering meeting.
0025 (1) Annual monitoring of clozapine treatment in St Mary's House	• To raise awareness amongst consultant, clozapine clinic, and junior doctor staff on the expectations around annual physical health monitoring • To improve guidance on how to approach medical reviews of the results, and where to find the results • To improve quality of communication with general practice • To improve the monitoring pathway to ensure results are reviewed and communicated to the GP in a timely fashion • Presentation of audit results, and proposed changes to consultants, junior doctors, clinical leads and clozapine clinic staff • Guidance document for junior doctors regarding expectations and support around clozapine monitoring. The document can be kept in the office in paper format, and forwarded in email format as part of their induction to the rotation • Standardised letter format to guide communication with the GP • Service improvement work around safety-netting and streamlining the pathway
0281 (1) Audit of completion of MEWS assessment forms for perinatal in-patients	• The team needs to highlight to staff the importance of improving on these figures to ensure patients have the required monitoring and interventions. • This will be done by emailing staff findings, discussing the rationale for recording each item at the ward meeting and identifying training needs there. • Agreement and maintenance of a process to ensure MEWS are accessible at all times in order for clinical condition tracking and recognition of deterioration in case of an emergency. A discussion was held to agree storage of the MEWS for current in-patients so that they are easily accessible (all forms to be stored in readily identifiable folder in clinic room). The availability of a MEWS will also be checked at each MDT review. • To introduce the newer version of the MEWS which incorporates other observation charts, reducing repetition and having relevant information in one space. • MEWS to be done weekly (and if there are any clinical changes).
0180 (1) Audit of East ICS referrals to Forward Leeds	We will feed the results of the audit back to the East ICS clinical team. The main area for improvement identified in this audit was the attendance rates at follow up by Forward Leeds after referral. It was decided that in future we will: • Aim to record whether the patient being referred is motivated to attend follow up with Forward Leeds (in addition to the current information

Project number (cycle) and title	What are we going to do?
	gathered re the patient being aware and consenting). • Offer a Forward Leeds postcard to service users at the point of referral. • Reiterate need for Leeds Dependent Questionnaire (LDQ) to be completed.
0182 (1) Benzodiazepine use in old age psychiatry (Millfield House)	• To improve arranging regular follow up appointments for patients taking benzodiazepines/Z-drugs. • To review the doses prescribed and the need for continued prescription in order to comply with British National Formulary (BNF) standards of dose ranges and short-term use of Benzodiazepines/ Z-drugs. • To improve the use of non-pharmacological measures to improve symptoms prior to drug therapy and evidence of this should be documented. • To improve documentation and specification for Benzodiazepines/ Z-drugs prescription. • To raise awareness of clinicians to ensure that any patients seen should be under their team's caseload. In addition, verification of patient's current prescriptions should be sought and documented clearly • Discuss and share audit findings with prescribing clinicians within the Millfield House team and Clinical Improvement Forum – suggest putting a system in place (internal process) that will prompt the patient to attend regular follow up appointments. • Discuss in multi-disciplinary team meeting as a reminder of good practice. • Discuss creating an assessment template (tick box) to show evidence • To provide a copy of the audit for the induction pack for new doctors Drs joining the team • Send email of audit findings to clinicians within the Millfield House team, to enforce reviewing caseloads and verifying patient's current prescriptions. • Discuss in multi-disciplinary team meeting if this could be put as a Standard Agenda Item (reminder) and can be reviewed every six months or yearly.
0289 (1) Driving in dementia (SSE CMHT)	• To raise awareness of the importance of documenting whether a patient drives or not • To improve practice by encouraging clinicians to use and document giving patients the Alzheimer's Society 'Living with dementia: Driving' leaflet as evidence of informing them of the need to self-refer • To raise awareness of the importance of re-checking driving status at diagnostic appointment even if it has been documented at previously.
0290 (1) Analysis of assessment and documentation of patients capacity during admission at South South East Intensive Community Service (SSE ICS)	Recommendations: • To improve awareness of the importance of capacity assessments in patients being admitted to hospital. • To improve quality and documentation of capacity assessments in PARIS notes. Actions: • To feedback results of audit to CIF meeting. • To run short teaching session with ICS staff to feedback audit data and cover capacity. • To discuss and design an 'admission from ICS' pro forma (if agreed) including section on assessing capacity.

2.2.3 Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by Leeds & York Partnership NHS Foundation Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 1300.

1510 service users, carers and staff were recruited in total to research conducted in the Trust in 2017-18.

Recruitment was made up of:

- 1119 service users, carers and staff recruited to National Institute for Health Research (NIHR) portfolio studies
- 391 service users, carers and staff recruited to non-NIHR studies *i.e.* local and student.

The Trust was involved in 91 research studies across 13 clinical activity areas in mental health and learning disabilities in 2017/18. Interventional research made up 22% of the research in 2017-18, an 8% increase on 2016-17. This demonstrates our commitment to improving the quality of care we offer and to making our contribution to wider health improvement.

Figure 7 – Number of Research Projects by Year

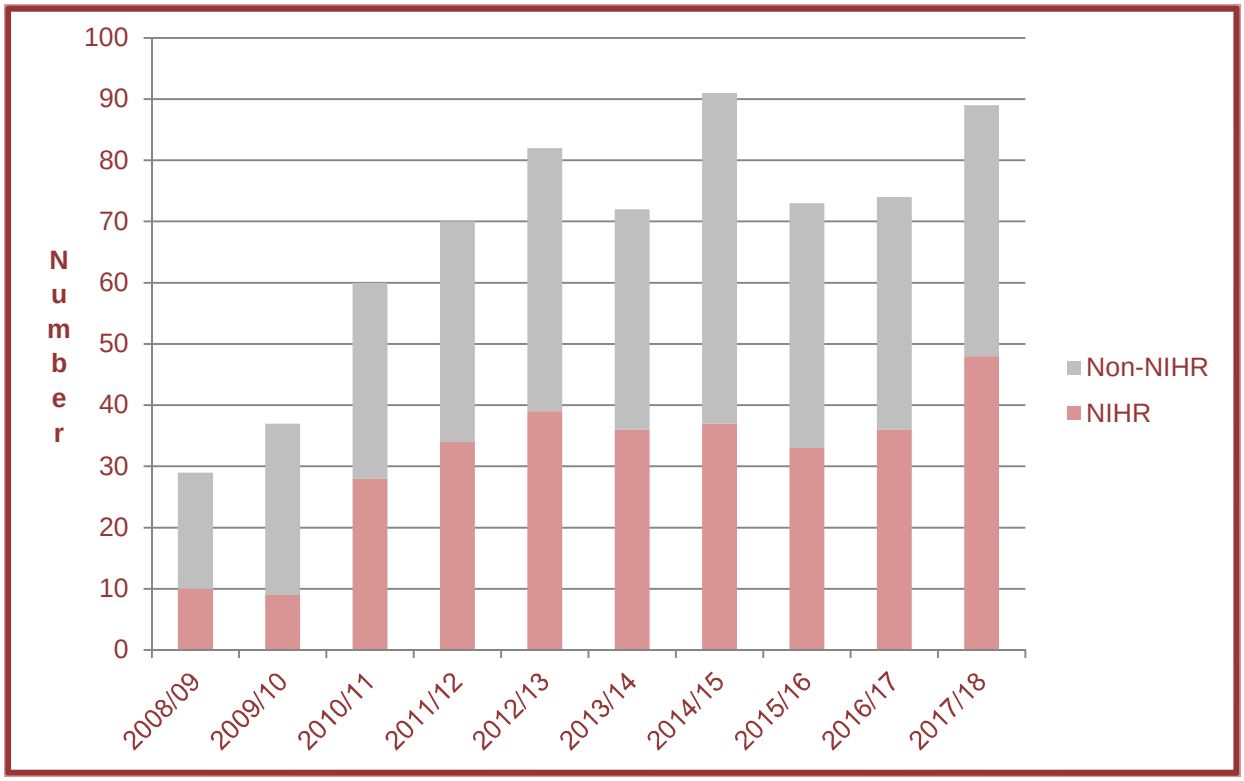
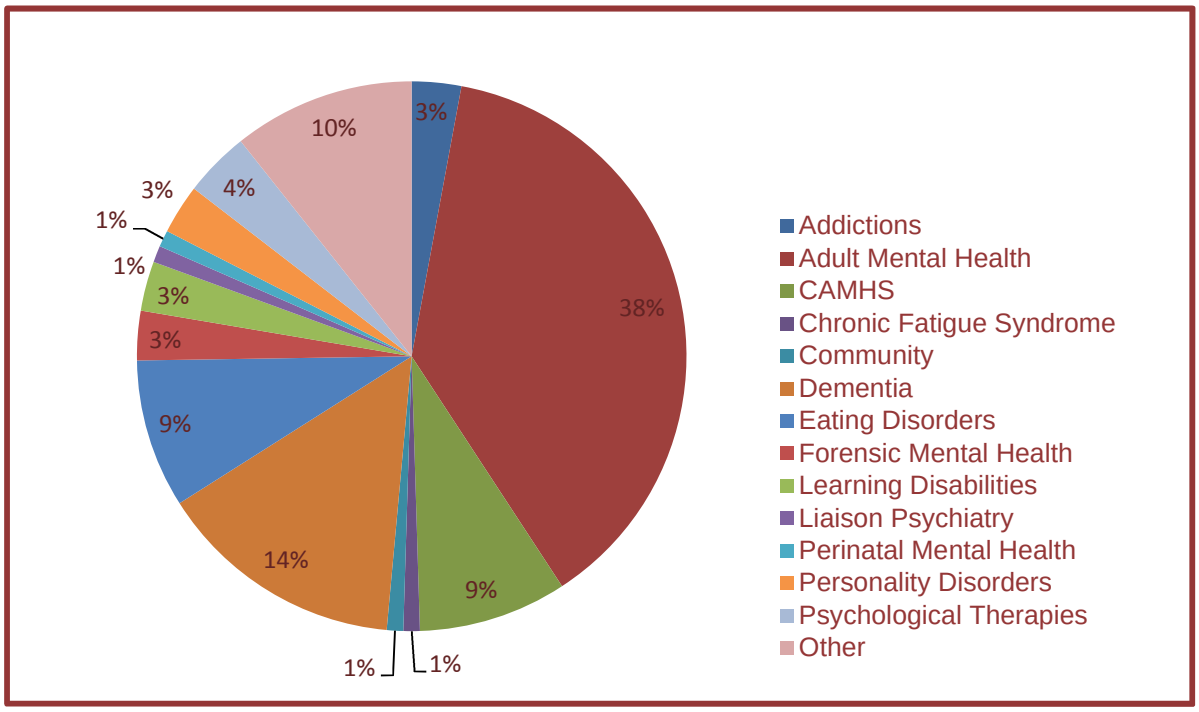


Figure 8 – Research studies by clinical activity area 2017-18



2.2.3.1 Research grants

Funding of £3.2m from the National Institute for Health Research was administered by the Trust in 2017/18. This funding was for four trials:

- Alleviating Specific Phobias Experienced by Children Trial (ASPECT): non-inferiority randomised controlled trial comparing the clinical and cost-effectiveness of one session treatment (OST) with multi-session cognitive behavioural therapy (CBT) in children with specific phobias
- Diagnostic Instruments for Autism in Deaf children Study (DIADS) – validation of autism assessment instruments for deaf children
- (I-SOCIALISE) Investigating Social Competence and Isolation in children with Autism taking part in LEGO-based therapy clubs In School Environments
- Trial on Improving Inter-Generational Attachment for Children Undergoing Behaviour Problems (TIGA-CUB).

2.2.3.2 Publications

There were 52 publications in 2017/18 related to research activity in the Trust.

2.2.3.3 Research Impact

Diagnostic Instruments for Autism in Deaf children (DIADS) are assessments that have been modified by the research team to be suitable for use with deaf children.

There are currently no suitable assessments for autism in deaf children, which can result in misdiagnosis. For example, some children have a language delay through deafness that mirrors a sign of autism. The aim of the research is to develop measures that will accurately detect deaf children with and without autism, reducing distress and ensuring appropriate services are provided. In order to achieve this, researchers drew on the knowledge and experience of 39 international experts to modify three autism assessments, which have been translated into British Sign Language.

The Trust has led on this research and has engaged very successfully with families nationally. The target of 260 families has been successfully recruited to test these assessments. The study results will be reported in early 2020.

The Trust is currently participating in Reducing pathology in Alzheimer's Disease through Angiotensin targeting (RADAR). This is a clinical trial investigating if losartan, which is usually used to treat high blood pressure, has additional properties that could slow down the progression of Alzheimer's disease. The Medical Research Council and National Institute for Health Research have invested nearly £2m in this work.

The Trust has led the way on this study, recruiting more patients to participate than any other Trust in England. Response from patients has been positive with twice as many volunteering than expected.

2.2.4 Commissioning for Quality and Innovation (CQUIN)

A proportion of the Trust's income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2017/18 and for the following 12-month period are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/.

The table below shows the monetary total for the planned amount of income in 2017/18 and 2016/17 conditional upon achieving quality improvement and innovation goals, and financial penalty incurred:

Table 21 – Planned income and penalty incurred

Planned Income	2017/18 £000	2016/17 £000
Leeds CCGs	2,281	2,258
NHS England	600	577

Penalty Incurred	2017/18 £000	2016/17 £000
Leeds CCGs	120	350
NHS England	0	0

The CQUINs in which the Trust failed to fully meet the required target were:

- National flu vaccine
- National physical health
- National staff health and wellbeing
- National risky behaviours.

Flu Vaccine:
Although we did not reach the full target for the flu CQUIN, we did achieve 75% of the target by ensuring that 65.6% of our workforce were immunised - which is a significant increase from 2016/17.

Improvement of health and wellbeing of NHS staff:
This CQUIN was 50% achieved as the national staff survey results only evidenced the required improvement in scores over the last two years in one of three required areas. However, significant improvements in working days lost in relation to both musculoskeletal problems and stress can be evidenced, demonstrating that actions being taken by the Trust are having an impact.

Physical health:
The results of the national audit of cardio metabolic assessment and treatment provision have not yet been published, so CQUIN performance was assessed based on the results of an internal audit conducted at the same time as the national audit. This showed full achievement against target levels for community services and 75% achievement for inpatient services.

There was a requirement for 90% of patients to have an up to date CPA (care programme approach), care plan or a comprehensive discharge summary shared with their GP. An audit showed that there was a reasonable level of compliance with the individual elements of the reporting requirements, but none of the cases in the audit sample met all of the reporting requirements. An action plan to address reporting issues is being developed, and work is continuing to enable electronic communications with GPs which is expected to improve the process.

Risky behaviours:
Targets in relation to the provision of brief advice for tobacco were not met in Q2 and Q4, In addition, in the provision of brief advice for alcohol target was not met in Q2. Contributory factors identified were the use of bank and agency staff in inpatient services, who do not always have the knowledge and skills of substantive staff, and lack of clarity around the alcohol pathway following a change of community services provider. Steps have been taken to raise awareness of the provision of tobacco and alcohol brief advice and training in relation to this with staff across the Trust.

2.2.5 Care Quality Commission (CQC)

The Trust is required to register with the Care Quality Commission. Its current status is fully registered with no conditions applied.

The Care Quality Commission has not taken enforcement action against the Trust during this reporting period.

The Care Quality Commission inspected the Trust during the reporting period. The services that were inspected were:

- Acute wards for adults of working age and psychiatric intensive care units
- Forensic inpatient or secure wards
- Child and adolescent mental health wards
- Wards for people with a learning disability or autism
- Mental health crisis services and health-based places of safety
- National Inpatient Centre for Psychological Medicine
- The Specialised Supported Living Service.

The Trust was inspected between 8 January and 31 January 2018 as part of the Care Quality Commission's comprehensive inspection programme. We submitted a comprehensive action plan to CQC in May 2018 and are actively working through this. The timeframe for completion is December 2018.

What the CQC Report said:

Service users and carers have given us overwhelmingly positive feedback on how they're treated in the latest inspection report from the Care Quality Commission (CQC).

In the report they said staff were 'caring and compassionate during their interactions with patients' and that 'feedback from patients confirmed that staff treated them well and with kindness, compassion and respect.'

The report also stated 'patients were positive about the care and treatment they received and felt involved in the decision-making' and that 'staff involved carers and others close to patients in decisions about the care and treatment provided by the service.'

The report shows that 85% of the Trust's services are now rated as either good or outstanding. However there are still a number of issues to resolve including three services rated as 'Requires Improvement' alongside some actions the Trust needs to take centrally. As such the Trust has been rated 'Requires Improvement' overall.

The reports and ratings have been published on the CQC's website.

Inspectors assess services against five key questions, asking if services are safe, effective, caring, responsive and well-led. They then rate both NHS Trusts as a whole ('provider level') and their individual service areas to help people understand where care is outstanding, good, requires improvement or inadequate.

Figure 9 – Summary of our overall CQC Trust rating

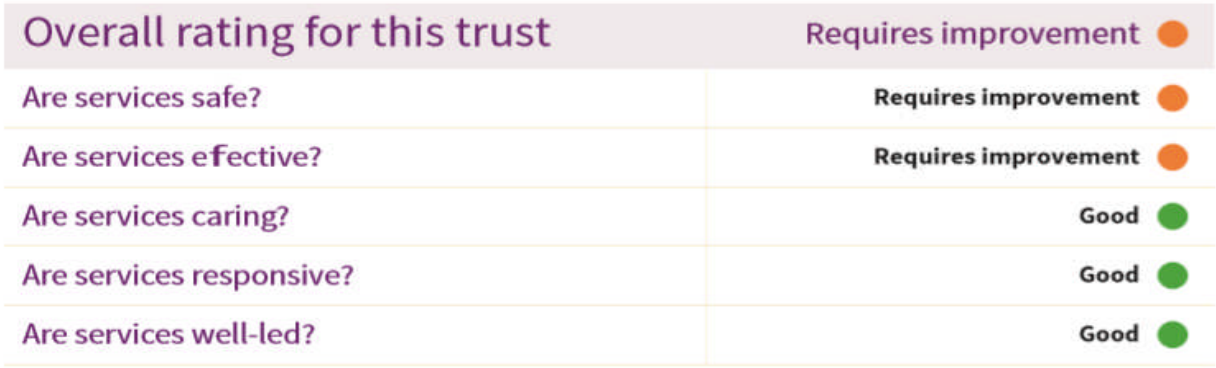


Figure 10 – CQC ratings for individual services

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement →← Apr 2018	Requires improvement ↓ Apr 2018	Good →← Apr 2018	Good →← Apr 2018	Good →← Apr 2018	Requires improvement ↓ Apr 2018
Long-stay or rehabilitation mental health wards for working age adults	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Forensic inpatient or secure wards	Requires improvement →← Apr 2018	Requires improvement →← Apr 2018	Good →← Apr 2018	Good →← Apr 2018	Good ↓ Apr 2018	Requires improvement →← Apr 2018
Child and adolescent mental health wards	Good ↑ Apr 2018	Good →← Apr 2018	Good →← Apr 2018	Good →← Apr 2018	Good →← Apr 2018	Good →← Apr 2018
Wards for older people with mental health problems	Good Nov 2016	Requires improvement Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Wards for people with a learning disability or autism	Requires improvement →← Apr 2018	Requires improvement →← Apr 2018	Requires improvement ↓ Apr 2018	Good →← Apr 2018	Requires improvement →← Apr 2018	Requires improvement →← Apr 2018
Community-based mental health services for adults of working age	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Mental health crisis services and health-based places of safety	Good ↑ Apr 2018	Good ↑ Apr 2018	Good →← Apr 2018	Good →← Apr 2018	Good ↑ Apr 2018	Good ↑ Apr 2018
Specialist community mental health services for children and young people	Good Nov 2016	Good Nov 2016	Outstanding Nov 2016	Outstanding Nov 2016	Outstanding Nov 2016	Outstanding Nov 2016
Community-based mental health services for older people	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Community mental health services for people with a learning disability or autism	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
National Inpatient Centre for Psychological Medicine	Good ↑ Apr 2018	Outstanding ↑ Apr 2018	Outstanding ↑ Apr 2018	Requires improvement ↓ Apr 2018	Good →← Apr 2018	Good →← Apr 2018
Overall	Requires improvement →← Apr 2018	Requires improvement →← Apr 2018	Good →← Apr 2018	Good →← Apr 2018	Good ↑ Apr 2018	Requires improvement →← Apr 2018

In a separate CQC Inspection, the Specialist Supported Living Service was inspected on the St Mary's Hospital site on 4, 5 and 6 December 2017 and 1 and 2 February 2018. The inspection was announced because CQC wanted to ensure service users, their relatives and staff were available to support the process.

Figure 11 – Summary of the CQC outcome

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Outstanding
Is the service responsive?	Good
Is the service well-led?	Good

What happened next?

The Trust developed a plan of action and recommendations based on the inspection team's findings as set out in the inspection reports. The Trust keeps track of these actions using an electronic tracker tool and by holding regular CQC project team meetings.

The Trust submitted its final action plan to the CQC in May 2018.

The Trust is already addressing a number of the issues raised in the report, for example:

- Improving the rates of clinical supervision by embedding a new central system.
- Investing in our patient records system to make it easier for staff to use, improve record keeping and to get better information out of it.
- Progress on finding more suitable accommodation for the National Inpatient Centre for Psychological Medicine. The Trust is in a constructive dialogue with partners at Leeds Teaching Hospital.

The Trust expects a follow-up inspection of the areas that are rated 'Requires Improvement' within the next 12 months.

The Trust also holds regular quality peer reviews across all areas of the Trust which bring to light more quality improvement actions that can be added to the tracker. In this way we are continuously improving and sharing best practice across services.

2.2.6 Participation in specialist reviews

The Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

2.2.7 Submission of records to the secondary uses

The Trust submitted records during the period 1 April 2017 to 31 March 2018 to the Secondary Uses Service for inclusion in the hospital episode statistics which are included in the latest published data.

The percentage of records in the published data that included the patient's valid NHS number was:

99.4% for admitted patient care,
99.6% for outpatient care and,
N/A for accident and emergency care,

Practice Code was:
99.9% for admitted patient care;
99.8% for outpatient care; and,
N/A for accident and emergency care.

2.2.8 Information governance

The Trust's Information Governance assessment report overall score for 2017/18 was 78% and graded 'Satisfactory' (green).

The Information Governance Toolkit is a Department of Health (DH) policy delivery vehicle that NHS Digital is commissioned to develop and maintain. It draws together the legal rules and central guidance set out by the DH policy and presents them in a single standard as a set of information governance requirements. The organisations in scope of this are required to carry out self-assessments of their compliance against the information governance requirements.

The self-assessment is validated by an annual internal audit programme, which corroborates the assurance provided by checking a selection of the standards each year. Ten requirements were audited in 2017/2018.

The Trust's final Information Governance assessment report against the NHS Digital IG Toolkit for 2017/18 was 78% and graded 'Satisfactory' by virtue of achieving Level 2 on all applicable standards.

2.2.9 Payment by results clinical coding error rate

The Trust was not subject to the Payment by Results clinical coding audit during 2017-2018 by the Audit Commission.

The provider is however required to carry out this audit under NHS Digital IG Toolkit Requirement 514. The error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) was:

- Primary Diagnoses- 100%
- Secondary Diagnoses- 97.27%
- Primary Procedures- 100%
- Secondary Procedures- 100%

This gives the top rating of Level 3 for the Information Governance Toolkit requirement 514. The results should not be extrapolated further than the actual inpatient sample audited.

2.2.10 Data quality

The Trust has taken the following actions to further improve data quality during 2017/18:

- Undertaken an internal audit of data quality to provide a baseline to work from
- Appointed two new members of staff to lead the data quality agenda (Head of Performance Management and Informatics, and Data Quality Manager)
- Rewritten the Trust's Data Quality Policy to clarify roles and responsibilities in regard to clinical record keeping and data quality
- Established a clinical record keeping and data quality framework to provide assurance to and governance for the organisation
- Developed routine reporting of data quality measures at local level backed up by completeness monitoring from the Data Quality Team
- Given prominence to data quality monitoring issues as part of the monthly Performance, Information and Data Quality Group (PIDQG) attended by senior members of operational management, informatics and performance management
- Included data quality updates as a standing agenda item in the monthly Information Governance Group
- Continued to monitor and publish performance against national and contractual data quality metrics in a new version of the Trust's Combined Quality Performance Report (CQPR).

The Trust will be taking the following actions to improve data quality during 2018/19:

- Embed the new clinical record keeping and data quality framework within the organisation

- Undertake a communications drive around the importance of clinical record keeping and data quality
- Continue to raise awareness throughout the organisation of key clinical record keeping processes that impact on data quality and performance
- Undertake the development of routine local data quality audits as part of a new kite-marking process
- Develop and embed the CQPR at Board and subcommittee level
- Develop and embed quality and performance information via dashboards at service, team and care group level.

PART 3 – OTHER INFORMATION

3.1 PATIENT ADVICE AND LIAISON SERVICE, COMPLAINTS AND COMPLIMENTS

The Trust wants to work with anyone who has a complaint in a fair, open and honest way. If there are any issues found, we share the lessons learned across the whole Trust.

3.1.1 Patient Advice and Liaison Service (PALS)

In 2017/18, the Trust received 1,772 enquiries to our PALS team. This is a 6.5% increase from 2016/17. The significant increase can be attributed to the presence of PALS staff within inpatient units. This is to promote the service of the PALS team and to speak to those service users or their carers and relatives who may have any queries or concerns. PALS have had an increase in email contact, due to dealing with the Trust's general enquiry email inbox.

Our PALS team responds to each case on an individual basis and records the reason for the contact as well as the outcome.

The majority of PALS contacts are either general concerns with patient care or callers wanting advice and information about services the Trust provides. This may involve contact with clinicians, sign posting to external agencies, other PALS services or to our complaints team.

For a large number of PALS contacts, the outcome is the provision of advice/information and resolving concerns. A number are referred on to Trust services, external agency, PALS services, or our complaints team.

The PALS team also includes student social workers on a placement basis, working alongside employed staff members, to offer a rich and more visible advice and liaison service across the Trust.

The PALS team also offer the opportunity for volunteers to gain some experience within our mental health trust.

3.1.2 Complaints

In 2017/18, the Trust received 193 formal complaints from service users, relatives and advocates. This represents an overall increase of 3.2% compared with 2016/17.

Since Quarter 2, complaints have steadily decreased. The team is reviewing the process to ensure that wherever possible complaints can be resolved as quickly as possible and in the best way for the complainant.

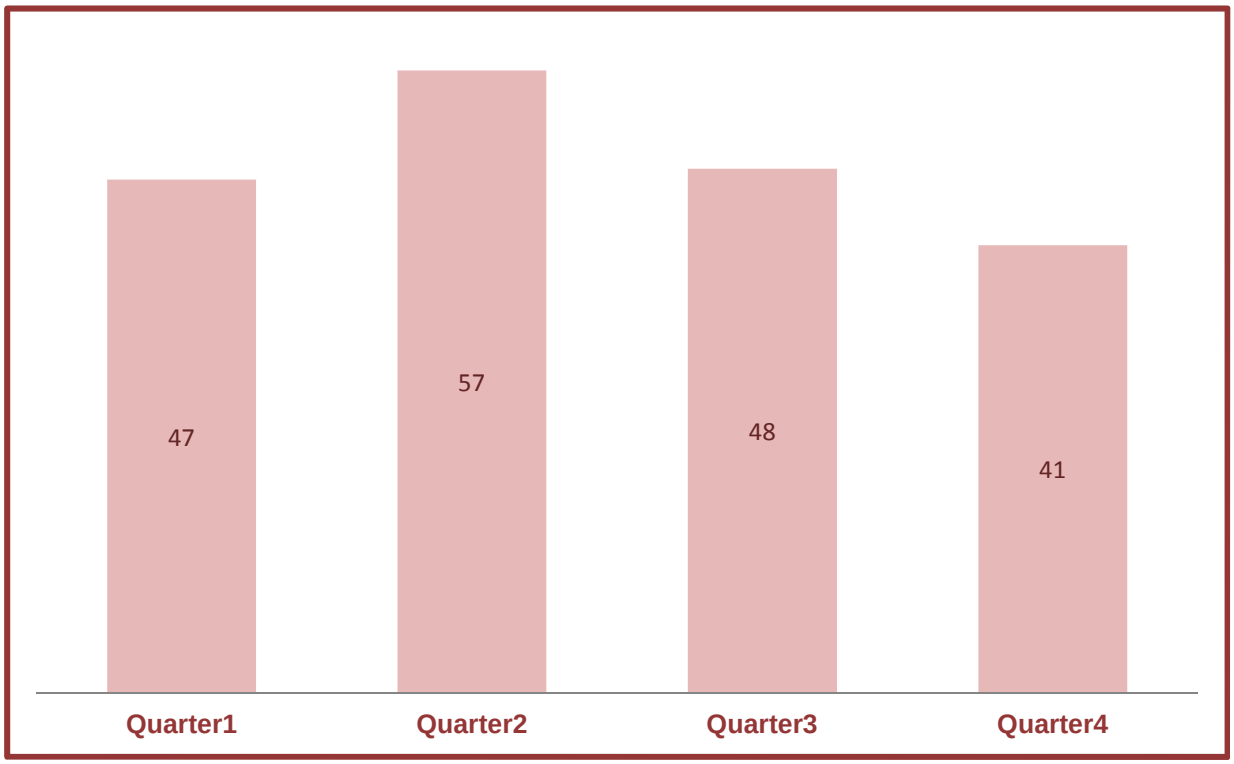


Figure 12 – Number of complaints received by quarter (2017-2018)

Complaints are seen as a valuable source of feedback which can be used to inform service improvements, enabling us to provide high quality services for our patients and carers.

Complaints management training has been in place since May 2015 and more than 150 members of staff have been trained in the handling of complaints. Feedback from the training highlighted a need for additional customer service training for front-line support staff (bands 2 and 3). As a result, a 'customer services' training package was developed. A total of 14 sessions were held in 2017/18 aimed at front-line support staff as they represent the face of the Trust and are the ones whom visitors/callers speak to first and the people staff go to first for information. Good front-line staff create an environment where courtesy, helpfulness and a warm welcome are standard.

The Trust recognises the importance of learning from complaints and the value of sharing this learning across the organisation. Complaints present an opportunity to review patient care, our services, and the way in which we interact and provide information to our service users.

Once a complaint has been investigated, the complainant is informed within the response letter, where action will be taken to ensure the events leading to their experience are put right. Often this may involve individual staff members reflecting on the way they have provided care, team discussions for wider group learning, staff training or use of the complaint as a case study.

A CLIP (Complaints, Litigation, Incidents and PALS) report is provided for each of the care groups on a monthly basis and discussed within the relevant forums. Complaint actions are discussed within care group risk forums.

3.1.3 Compliments

Staff often receive compliments by letter or card, verbally or via a gift. They are thanked for treatment, care and support, or complimented on the environment, atmosphere, and cleanliness of the ward. Staff are able to report all compliments received (either written or verbally) as well as being able to attach any cards/letters to the DATIX system.

Compliments are a key measure of patient experience and we would therefore like to be in a position to consider compliments alongside complaints, aiming to create a stronger patient focus and further develop a culture that learns from feedback.

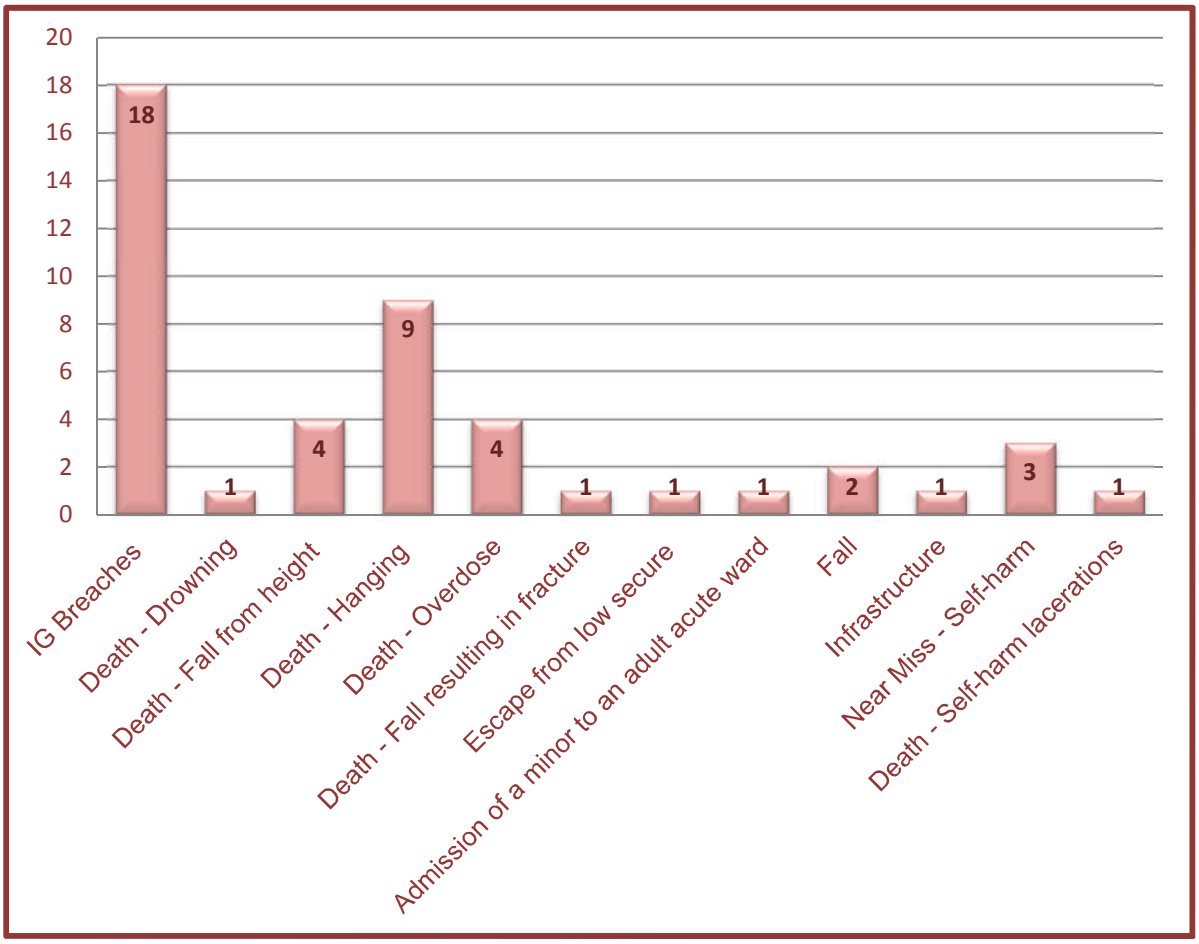
During 2017/18, the Trust received 343 formally recorded compliments.

3.2 SERIOUS INCIDENTS

During 2017/18, 46 serious incidents requiring investigation were reported by the Trust and the types of incidents are seen in Figure 13. This year saw a 24% decrease in the numbers of reported serious incidents: 61 were reported in 2016/17, 50 were report in 2015/2016, 44 were reported in 2014/15, 27 were reported in 2013/14 and 28 were reported in 2012/13. The most frequently reported serious incidents requiring a full comprehensive investigation are suspected suicide, unexpected death and incidents of self-harm.

The Trust reported nil never events during 2017/18. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Figure 13 – Type of serious incidents reported 2017-2018



3.2.1 Learning lessons

A review of the last three years of serious incidents was completed in November 2017 to identify the key themes across the two care groups and to achieve a detailed understanding of the demographic information, to formulate a better understanding of the learning and to identify any gaps in the action plans.

The decision to undertake an investigation is now agreed through the Learning from Incidents and Mortality Meeting (LIMM). This group agrees terms of reference and allocation of the investigator. The Trust has recently changed the process of investigation to provide a supportive, compassionate approach to staff, with the introduction of 'Learning Reviews', therefore where possible, avoiding one to one traditional interviews to enable teams to reflect and share learning. An important element of this approach is for teams to highlight good practice and to establish any root cause or contributory factor. Staff have reported that they have found this approach supportive and it has enabled an open and honest discussion. In addition this approach ensures that teams are involved in the recommendations and action plan, rather than this being seen as something remote and removed from the team. This also avoids the issue of human error, evidenced in the RCA2 Improving Root Cause Analysis and Actions to Prevent Harm, which notes the importance of understanding that system and process change is key to preventing harm in the future, rather than a focus on an individual.

The themes identified by both care groups include:

- Systems/processes/procedures
- Workforce
- Treatment/care plan
- Documentation and record keeping
- Care Programme Approach (CPA) and care coordination
- Service user and carer involvement.

The detail within the themes includes unclear pathways and poor written, electronic and verbal communication systems between professionals (both internally and externally) as well as a lack of guidelines to support clinical practice, workload of care coordinators and risk training. Standards of record keeping, including documentation of multi-disciplinary team discussion, and absence of family in care provision because there is no carer engagement.

3.2.2 Top themes

In order to improve the care and treatment highlighted within the themes, a number of quality improvement projects are in progress, including the following:

- Care and Safety Planning and Recovery (CASPAR) which encompasses the elements of Care Programme Approach and care coordination.
- Improving the management of patients at the time of transition between services.
- Patient safety planning project.
- Procurement of a new patient record system to improve standards of documentation.
- Strategies for working with difficult to engage service users to share the learning, and develop a quality improvement project to improve care for complex patients.
- Triangle of Care group which is improving communication with service users and families in line with NICE guidance.
- Community mental health inclusion criteria to provide clear guidance for CMHTs to enable them to provide a consistent approach for teams with regards to referrals and to support the workload of care coordinators.
- How to reduce drug use in inpatient wards, drug availability and respond to ongoing use.
- Development of improved links and a more effective service with Forward Leeds as key partners in care of patients.
- Improving access to psychological interventions and improved multi-disciplinary team working.
- Devolvement of community models to reflect the need of service users in the future.

Following the review of the three years of serious incidents it has been identified that the Trust requires further improvement in relation to the development of action plans as part of the serious incident PDSA cycle, in order to ensure the actions are specific, measurable, achievable, relevant and time specific (SMART). There are a number of actions that have been completed but without the evidence to support this.

The Trust is undertaking a significant amount of work to improve the care of service users, which is evidenced through the quality improvement work. Future quality improvement projects should continue to reflect the themes and learning from Serious Incidents to further improve learning. However, further work is required with regards to the serious incident process and learning from harm to ensure a more robust action planning process is established. The Trust is working with the Sustainability and Transformation Partnership footprint to share themes and trends from Serious Incidents, as it is recognised that the majority of mental health trusts within the region have similar themes and learning identified. This will include a 'Learning from Deaths' Conference in 2018.

3.2.3 HM Coroner inquests

During 2017/2018 (as of 10 April 2018), 23 Coroner inquests were held (please note this is the date the inquest was held and not related to the date of the incident).

Table 22 – Summary of inquest conclusions

Conclusion of inquest held	Number of inquest types
Accidental	1
Drug and/or Alcohol Related	6
Misadventure	3
Natural Causes	2
Open	2
Suicide	12
Total	**26**

No Regulation 28 reports were issued to the Trust by the Coroner within this period.

3.3 SAFEGUARDING

Following the CQC inspection and their feedback in 2016, the team is now fully staffed and has an electronic system in place to record outcomes for the work the team has been carrying out. We are now looking at how we can use Datix more effectively in order to record team activity and outcomes.

The team have continued to contribute consistently to the external partnership Safeguarding Boards and sub committees and fully supported the 2017 White Ribbon Campaign. An increase in referrals to the team and attendance at Multi Agency Risk Assessment Conferences (MARACS), has limited the teams availability to always attend the front door safeguarding hub daily domestic meeting, this is a system-wide challenge and is being discussed across the health economy.

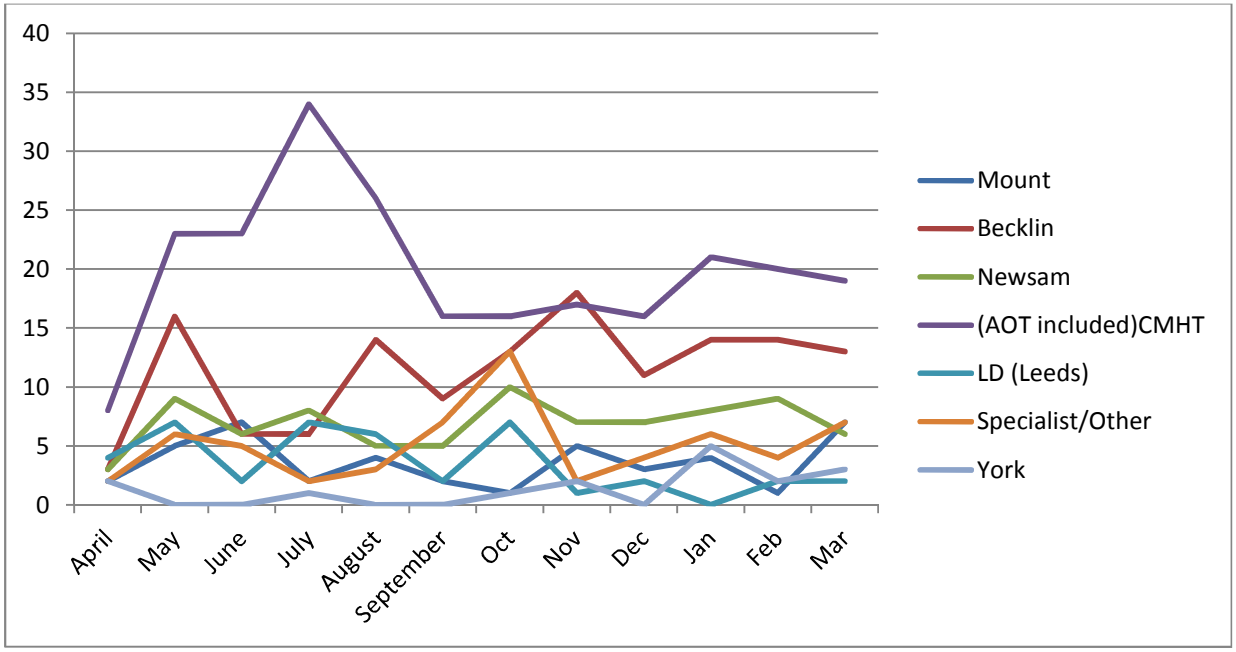
A new supervision policy and transitions policy has been ratified and updates have been made to the safeguarding policy to include PREVENT, children visiting mental health services, domestic abuse and visitor's access policies. A supervision training programme has been commenced and we are now reviewing the effectiveness of this based on staff feedback.

The team have carried out audits against the PREVENT policy and the children visiting policy. A further audit looking at domestic abuse has also been carried out which has focused on actions from the front door safeguarding hub and stalking and harassment have been completed.

A new training needs analysis and strategy has been completed and are being rolled out with the aim to make it easier for staff to meet their compulsory training requirements.

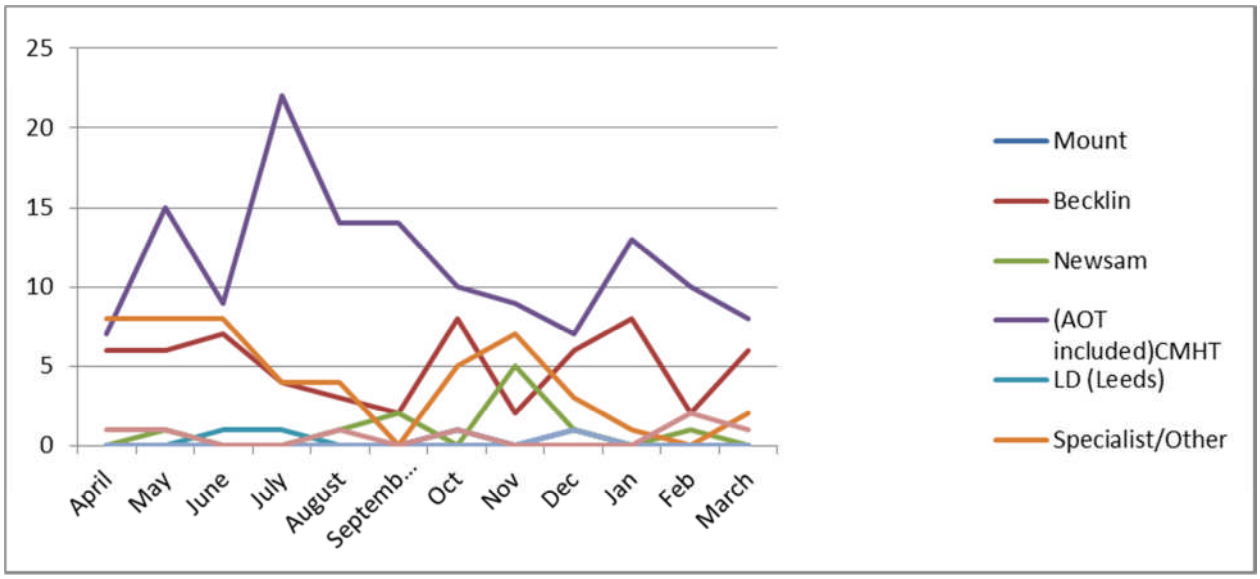
The charts below show the activity that the Safeguarding Team have carried out for both Adults and Children between April 2017 and March 2018.

Figure 14 – Safeguarding Adults Referrals and Advice April 2017-March 2018



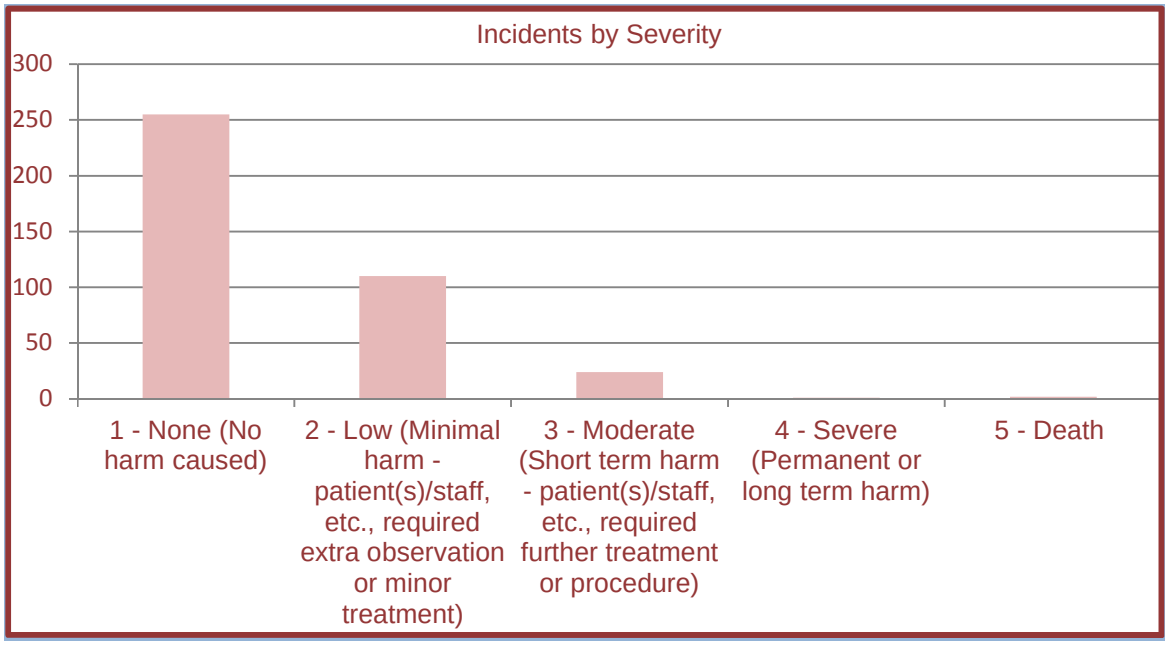
The chart above shows, as expected, that community is the highest reporter of concerns, peaking in summer 2017. Overall, the amount of advice provided has risen over the quarter and is in line recent trends.

Figure 15 – Safeguarding Children Referrals and Advice April 2017-March 2018



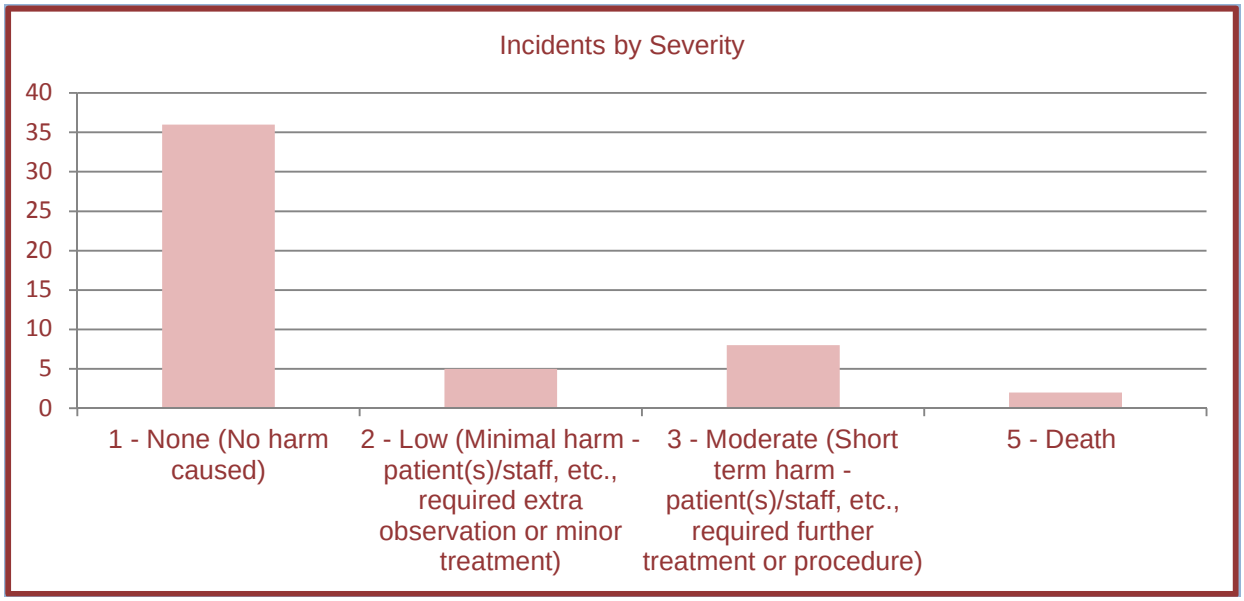
The chart shows a general downward trend in concerns over the summer period, countered by a peak in summer by community. The community remains the highest area in reporting concerns.

Figure 16 – Adult incidents recorded by severity April 2017-March 2018



(Source: Datix)

Figure 17 – Child incidents recorded by severity April 2017-March 2018



(Source: Datix)

3.4 SERVICE USER NETWORKS

The Service User Network (SUN) is a monthly meeting where service users and carers meet to share their experiences of Trust services, as well as providing a platform to support the shaping and influencing of service provision and development. Guest speakers are invited at the request of members where issues have been identified or raised within the network. Members also have the opportunity to become involved in research projects, delivering training and recruitment.

April 2017 to March 2018 saw 282 people attend throughout the year, and work is currently in progress to increase membership further with a particular focus on hard to reach and diverse communities. SUNRAYS has also been set up in locality areas to provide a similar platform to help

extend our ability to reach a wider group of stakeholders and the team are keen that working in partnership with other statutory, third-sector and voluntary organisations will help us to achieve our end goals. Our York-based services will also be supported to feel more included and share their experiences.

SUN members work closely with the Trust in order to help improve the services it provides and ensures consultation on appropriate Trust policies, procedures and service provision. There is a very welcoming and friendly atmosphere.

Although the SUN started off as an informal meeting, attendance at the meetings is now collated to provide evidence of the efficacy of the meetings and as a route to consultation, sharing information in the public domain and gaining specific feedback. SUN encourages people to express their views, share their experiences and explore what works well in our Trust and what areas may need improvement. Being part of the network means people feel they are being valued and get actively involved with their own care and treatment. Members of staff with lived experience are also welcome to attend.

The meetings are chaired and organised by a Patient Experience and Involvement Coordinator who is supported by a volunteer to take minutes. The Patient Experience and Involvement Coordinator has their own lived experience of accessing services, and has been able to use their experience to support others in chairing sessions and acknowledging the specialist support that people may require to 'tell their story' to groups of individuals.

There is further work to do in terms of making improvements to the function of SUNRAYS to improve ownership and engagement in community services; but a positive of the SUN and SUNRAYS groups is that issues raised are often addressed immediately by services in attendance at the meetings. SUN currently feeds into the Leeds Clinical Governance Council meeting where any issues raised are discussed and actioned. SUNRAYS encourage more people to attend, including staff members, and meetings are planned bi-monthly, chaired by two service users, with support.

SUN members have over the last twelve months contributed to, and influenced, a number of quality improvements. A few examples are noted below:

- Quality Strategy and Quality Report

Service users commented on the number of abbreviations used in the document that made it difficult for a lay person to understand. The members recommended an easier read version, keeping information sharing simple.

- Prevention and Management of Violence and Aggression (PMVA)

'Restraint in a hospital setting' saw the anti-stigma co-ordinator lead in the production of a video which was taken to the Trust Board regarding people's experiences of being restrained in hospital. The learning from this has been shared through the lead PMVA tutor and the lead for restrictive interventions to improve practice and training.

- Intensive community services (ICS) benchmarking project

Service users were interviewed by a graduate trainee in June 2017 to gain in depth information about their experiences in ICS services. The graduate trainee then attended a SUNRAYS meeting to gain more participation. Feedback has contributed to the outcomes in the project report.

- Trust website - NHS visual identity

A member of the Communications Team presented the new website to SUN members in April 2017 as a way of testing the improvements. Feedback from members included agreement that the website was less cluttered, information is easier to find and also included suggestions from members for further improvement such as providing an audio link for headphones.

- Service User Network and Sunrays new logo

Three choices of logo were presented and service users voted on the current logo which is a full sun and the SUNRAYS is half a sun.

A key area for the Patient Experience and Involvement Team is to ensure that we have a fit for purpose engagement model which is able to set out the fundamental principles of involvement and engagement activity in our organisation.

An external review will be undertaken at the end of April 2018 which will influence and provide key improvement plans for future experience and involvement across the Trust, ensuring that collating and learning from feedback at the right time and in the right place is embedded as routine practice.

The Patient Experience and Involvement Team will continue to be responsive during the review and is the process of designing a campaign to recruit volunteers who can help and support involvement, surveys, events, family and friend's feedback and other work streams.

3.5 SUNRAYS

A new group designed to bring together people with lived experience to help improve local mental health and learning disability services was officially launched in February 2017.

SUNRAYS is an offshoot of the Trust's Service User Network (SUN) group. As well as providing a forum for people to use their personal experiences to help improve services, SUNRAYS will encourage people to maintain their wellbeing whilst living in the community. There will be a focus on self-support and the groups, activities and information-sharing opportunities that exist in the local area.

SUNRAYS is open to anyone who has lived experience of accessing mental health services within the community. They can be a service user or a carer as SUNRAYS is all about working in partnership and putting personal experiences to practical use. There is a guest speaker at every meeting to give information or updates on the topics suggested by the group, and people who attend can access advice and support on the issues that matter to them. SUNRAYS is all about co-production, and there are opportunities for people to get actively involved by suggesting topics for discussion, or even chairing or co-chairing a group. There is also a real social element to the group.

This is a really exciting development for the Service User Network, and shows just how much the Trust values the service user voice.

SUNRAYS now meet every two months at Lovell Park (East Leeds) Stocks Hill (West Leeds) and The Vale (South Leeds). We actively encourage staff, service users and carers to come together to discuss local issues and promote mental wellbeing. The SUNRAYS in the South and West are chaired by service users in co-production and this is now the way forward.

This year, the Trust has commissioned an external review around patient experience and involvement, which will be concluded in 2018/19. The aim of this review is to continue to work alongside our service users and carers and to build on and improve the work we are already doing.

3.6 PLACE ASSESSMENT RESULTS

Table 23 – National results 2017

Category (with 2016 national averages shown)	National Average Score (2017)	Regional Average Score	Mental Health Site Type Comparison	Organisational Average (extracted from HSCIS place report 2017)
Cleanliness (98.20%)	98.38	98.40	98.40	99.37
	+0.99%	+0.97%	+0.97%	
Food (91.28%)	89.68	90.45 (average of ward, origin and tasting)	90.56	91.83
	+2.15%	+1.38%	+1.27%	
Privacy & Dignity (92.42%)	83.68	85.93	86.64	93.96
	+10.28%	+8.03%	+6.99%	
Environment (96.48%)	94.02	94.13	94.45	98.30
	+4.28%	+4.17%	+3.85	
Dementia (99.72%)	76.71	80.03	80.81	99.72
	+23.01	+19.69%	+18.91	
Disability (85.19%)	82.56	85.52	86.09	93.96
	+11.40%	**+8.44%**	**+7.87%**	

Table 24 – LYPFT PLACE scores

Site	% cleanliness		% food and hydration		% privacy, dignity and wellbeing		% Environment		% Disability		% Dementia	
	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017
Parkside Lodge	N/A		N/A		N/A		N/A		N/A		N/A	
The Mount	96.83%	99.49	90.54%	92.23	94.05%	95.40	98.56%	98.65		97.96	99.72	99.72
1-5 Woodland Square	99.62%	99.14	94.23%	92.44	89.73%	84.42	95.03%	96.16		91.37	N/A	
Newsam Centre	97.84%	98.70	93.35%	92.74	92.13%	95.27	95.49%	98.43		96.49	N/A	
Asket House	99.40%	99.74	N/A	N/A	89.86%	92.45	97.54%	99.63		97.96	N/A	
Liaison Psychiatry Inpatient Unit (YCPM)	100%		95.82%		86.33%		90.00%				N/A	
Becklin Centre	98.59%	99.83	89.62%	90.85	93.49%	94.64	95.57%	98.49		91.13	N/A	
Clifton House	99.61%	99.81	91.42%	90.85	92.64%	93.47	97.42%	98.30		93.96	N/A	
Mill Lodge Unit	98.84%	99.37	84.14%	90.85	87.38%	93.47	95.70%	98.30		93.96	N/A	
Asket Croft	98.60%	99.91	92.92%	91.83	90.77%	92.45	97.54%	99.56		93.84	N/A	
Trust Average	98.20%	99.37	91.28%	91.83	92.41%	93.96	96.48%	98.30	82.56	93.96	76.71	99.72
National Average	98.06%	98.38	88.24%	89.68	84.16%	83.68	93.37%	94.02	78.84	82.56	75.28	76.71

3.7 REPORTING AGAINST CORE INDICATOR MEASURES FOR SUCCESS

As part of NHS Information's requirement, the Trust must obtain assurance through substantive sample testing over one local indicator included within this Quality Report, as selected by the Council of Governors. The indicator chosen was: clinical outcomes have been improved for people who use our services (source: HoNOS assessment).

The table below provides a summary of the local and national indicators which have been included in this year's quality report and in which sections of this document further details can be found.

Table 25 - Summary of national and local indicators

Outcome Domain	Indicator	Most recent data	National Average	Best	Worse	Last report period	Last report period	Last report period	12 months 17/18	Place in document
Clinical Effectiveness : people achieve their agreed goals for improving health and improving lives	The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period. **	Q4 2017/18 95.33%		96.68%	94.33%	Q3 2017/18 94.33%	Q2 2017/18 96.68%	Q1 2017/18 94.42%		3.7
	The percentage of admissions to acute wards which the crisis resolution home treatment team acted as a gatekeeper during the reporting period.	Q4 2017/18 100%		100%	97.66%	Q3 2017/18 100%	Q2 2017/18 97.66%	Q1 2017/18 98.88%		
	The percentage of patients aged: (i) 0 to 16 and Readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.	Q3 2017/18 0%		0%	0%	Q2 2017/18 0%	Q1 2017/18 0%			
	(ii) 16 or over Readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.	Q4 2017/18 4.7%		2.6%	6.3%	Q3 2017/18 4.7%	Q2 2017/18 6.3%	Q1 2017/18 2.6%		
	Admissions to adult facilities of patients under 16 years old.	Q4 - 0		0	0	Q1 - 0	Q2 - 0	Q3 - 0		3.7.3

	Indicator	Most recent data	National Average	Best	Worse	Last report period	Last report period	Last report period	12 months 17/18	Place in document
Clinical Effectiveness : people achieve their agreed goals for improving health and improving lives	People report that the services they receive definitely help them to achieve their goals	2017 84%				2016 83%				3.61
	Clinical outcomes have been improved for people who use our services (CROMs) **	2017/18 62%				2016/17 65.98%				3.61
	The number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number of such patient safety incidents that resulted in severe harm or death.	2017/18 46 serious incidents				2016/17 61 serious incidents	2015/16 50 serious incidents	2014/15 44 serious incidents		2.1.2.1c, 3.2
Patient Safety: people experience safe care	Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas: a) Inpatient wards	2016 Smoking – 100% Alcohol – 100% BP – 100% BMI – 68% Glucose – 50% Sub misuse – 60% Cholesterol – 0%				2015 Smoking – 98% Alcohol – 86% BP – 88% BMI – 87% Glucose – 83% Sub misuse – 86% Cholesterol – 65%	2014 Smoking – 75% Alcohol – 50% BP – 68% BMI – 89% Glucose – 78% Sub misuse – 79% Cholesterol – 83%			3.7.1
	Community mental health services (people on care programme approach)	2016 Smoking – 85% Alcohol – 83% BP – 68% BMI – 78% Glucose – 86% Sub misuse – 91% Cholesterol – 80%				2015 Smoking – 69% Alcohol – 67% BP – 70% BMI – 44% Glucose – 43% Sub misuse –	2014 Smoking – 73% Alcohol – 80% BP – 65% BMI – 60% Glucose – 78% Sub misuse – 85% Cholesterol – 80%			3.7.1

Patient Safety: people experience safe care						57% Cholesterol – 0%				
	Indicator	**Most recent data**	**National Average**	**Best**	**Worse**	**Last report period**	**Last report period**	**Last report period**	**12 Months 17/18**	**Place in document**
	b) People who use our services report that they experienced safe care	81%								3.6.2
	Number of Trigger to Board events	2017/18 0		0	38	2016/17 0	2015/16 38			3.6.2
	NHS Safety Thermometer: improve the collection of data in relation to pressure ulcers, falls, urinary tract infection in those with a catheter and venous thromboembolism (VTE)	Feb 2018 99.5%	94%	100%	97.6%	Nov 2017 97.6%	Dec 2017 98.5%	Jan 2018 100%		2.1.2.1b 3.6.2
	The trust's 'Patient experience of community mental health services' indicator score with regarding to a patients experience of contact with a health and social care worker during the reporting period.	2017 – 88.4%	83.2%				2015 82.1%	2016 85.1%		2.1.3.1b
	Inappropriate out-of-are placements for adult mental	Q4 2017/18 405.7 days		109 days	411.3 days	Q3 2017/18 411.3 days	Q2 2017/18 294.3 days	Q1 2017/18 109 days	305.1 days	3.6.3

	health services. ** The definition is the average number of Inappropriate OOA bed days per month for the period stated. Calculation is the total number of bed days in the period/number of months in the period.									
Patient Experience: people have a positive experience of their care and support	People who use our services report definitely being treated with respect and dignity by staff providing care	2017 – 72..8%	70.2%				2015 67.3%	2016 73.3%		3.6.3

Key:	Local Indicator		National Indicator		Indicator audited	**

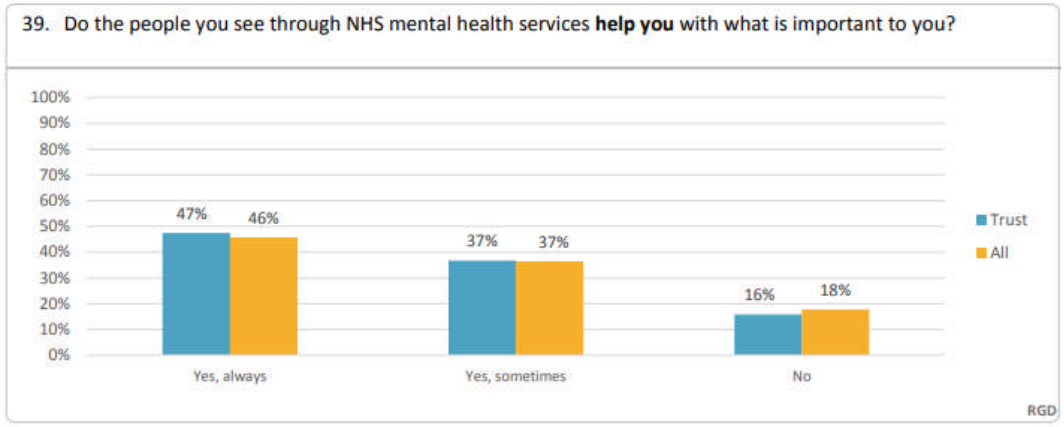
The Trust measures are set out under each priority as follows:

3.7.1 Performance of Trust against selected measures for Priority 1 (clinical effectiveness) - people achieve their agreed goals for improving health and improving lives

3.7.1.1 **Measure:** People report that the services they receive definitely help them to achieve their goals

Performance: In the National Service User Community Survey the wording has changed slightly to read 'Do the people you see through NHS mental health services help you with what is important to you?'

Figure 18 – Result of National Service User Community Survey regarding feeling helped



84% responded positively which is a 1% increase from last year.

(Source: National Service User Community Survey)

3.7.1.2 **Measure:** Clinical outcomes have been improved for people who use our services (CROMs)

Performance: During 2017/18 we have introduced a new streamlined Clinician Rated Outcome Measure (CROM) called the Clinical Global Impression Scale (CGI) which has been welcomed by clinicians as a simpler way of reporting service users' outcomes. We continue to report HoNOS and the percentage completed is 62%. Individual clinicians are able to review outcome scores for each of their service users through a report in PARIS.

Following an engagement and implementation phase for the CGI in 2017 we are now in a position to build outcome reports for clinicians to review their entire caseloads collectively. This will enable teams to focus work with service users on interventions which can be demonstrated to have positive outcomes for service users.

There is a Trust Wide Outcomes Group which was established in February 2018 reviewing best practice and sharing this across services and embedding and using outcome measures in clinical practice at individual and team level. This group will lead on introducing service user experience measures for all teams.

(Source: COGNOS)

3.7.2 Performance of Trust against selected measures for Priority 2 (patient safety) - people experience safe care

3.7.2.1 **Measure:** People who use our services report that they experienced safe care

Performance: 81% of those who responded to the NSUS inpatient survey declared that they felt safe always or sometimes during their stay in hospital.

(Source: National Mental Health Inpatient Service User Survey)

3.7.2.2 **Measure:** Number of patients safety incidents, by type and severity, including as % of total:

- % where 'no harm' has occurred (National Patient Safety Agency score 1)
- % where 'low harm' has occurred (National Patient Safety Agency score 2)
- % where 'moderate harm' has occurred (National Patient Safety Agency score 3)
- % where severe harm' has occurred (National Patient Safety Agency score 4)
- % where 'death' has occurred (National Patient Safety Agency score Death).

Performance:

Table 26 – Number of patient safety incidents by severity

Year	No harm	%	Low Harm	%	Moderate	%	Severe	%	Death	%	Total no. of incidents uploaded to NRLS
11/12	3755	74	1179	23	117	2		0	14	0	5065
12/13	3644	75	986	26	151	3		0	54	1	4835
13/14	4774	76	1412	22	80	1		0	23	0	6289
14/15	4883	75	1447	22	142	2	3	0	28	0	6503
15/16	4021	69	1630	28	127	3	2	0	23	0	5803
16/17	3342	68	1404	29	121	2	4	0	21	0	4892
17/18	3946	68	1687	29	184	3	5	0	15	0	5807

(Source: Datix)
(All service user incidents – inpatient and community)

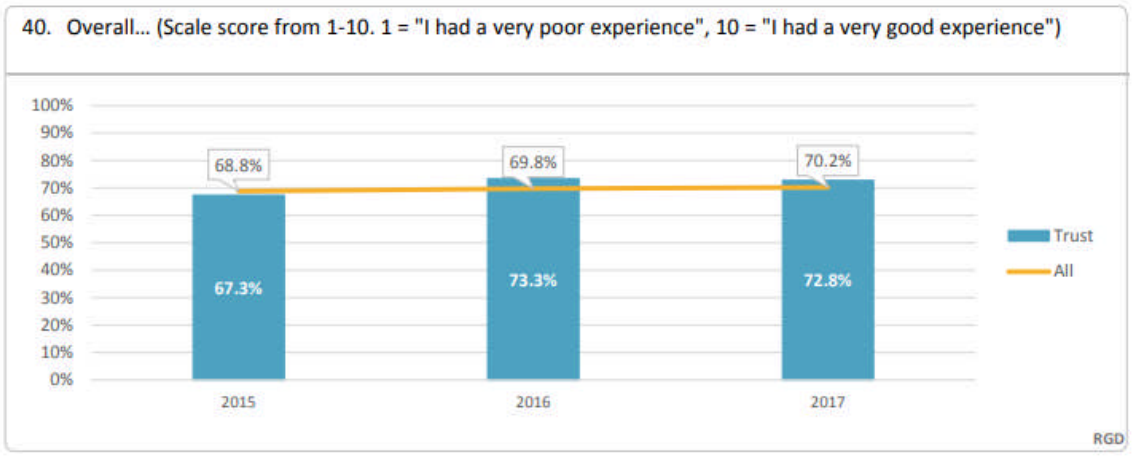
Performance: We have a high level of reporting and a low degree of harm when incidents occur. An organisation with a high rate of reporting indicates a mature safety culture. This maturity enhances openness and provides a truer reflection of current practice that allows for more robust action planning.

3.7.3 Performance of Trust against selected measures for Priority 3 (patient experience) - people have a positive experience of their care and support

3.7.3.1 **Measure:** People who use our services report overall rating of care in the last 12 months as very good/excellent.

Performance:

Figure 19 – Result of National Service User community survey regarding experience



213 service users responded to the 2017 National Community Service User Survey which is a 26% response rate. The survey is undertaken on behalf of the Trust by Quality Health, which surveyed a randomly generated sample of active service users between September and November 2016.

The Trust is in the highest scoring 20% of Trusts surveyed by Quality Health for this measure.

(Source: Mental Health Community Service User Survey)

3.7.3.2 **Measure:** People who use our services report definitely being treated with respect and dignity by staff providing care.

Performance: Once again the Trust's performance against this question in the National Service User Survey has improved.

Figure 20a - Result of National Service User community survey regarding respect and dignity

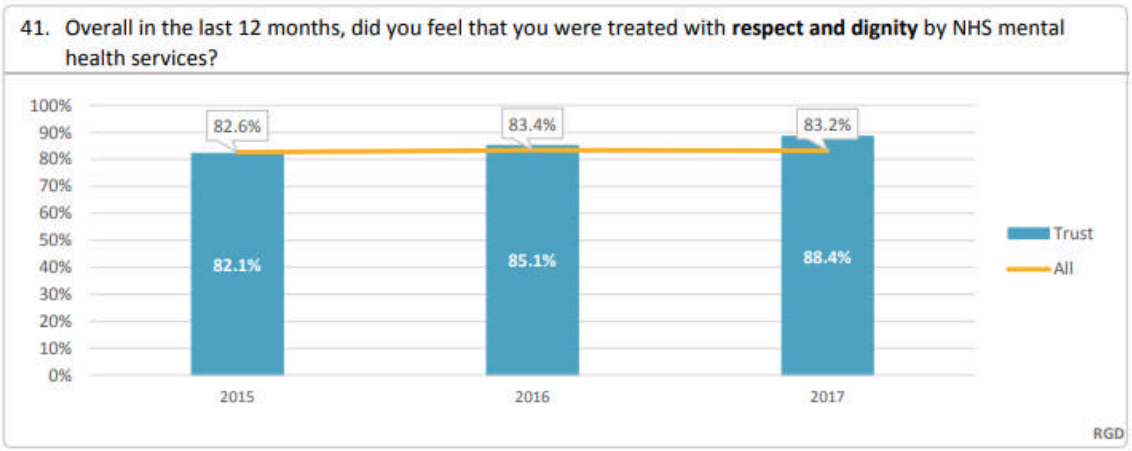
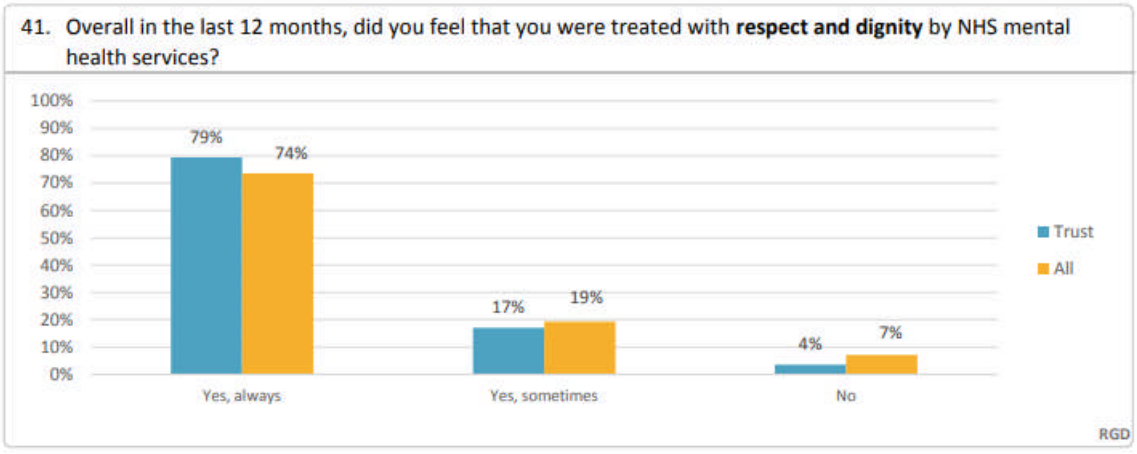


Figure 20b - Result of National Service User community survey regarding respect and dignity



The Trust is the highest scoring in the country against this measure with 88.4% of service users saying they were treated with respect and dignity by our staff.

(**Source:** Mental Health Community Service User Survey)

Measure: Carers report that they are recognised, identified and valued for their caring role and treated with dignity and respect.

Performance: The Triangle of Care is a national framework, developed by carers and NHS staff, to improve carer engagement in mental health services. It brings carers, service users and professionals together to promote safety, support recovery and sustain wellbeing.

The three-way partnership approach has made such a positive impact in Forensics that many of the growing network of 'carer champions' have gone on to train in behavioural family therapy. The network meets regularly to share experiences and knowledge, and each meeting hears personal stories filled with hope, frustration, gratitude, bewilderment, weariness and laughter.

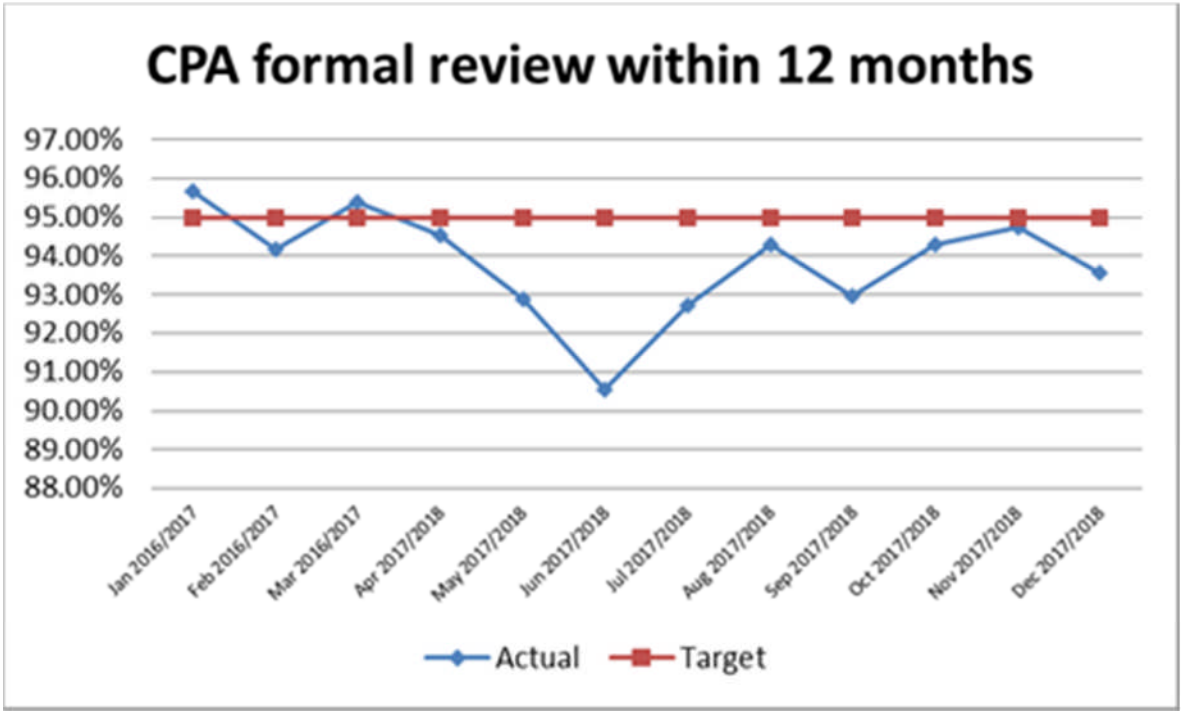
(**Source:** COGNOS)

3.8 NHS IMPROVEMENT TARGETS

Measure: Care Programme Approach (CPA) service users having formal review within 12 months: we must ensure that at least 95% of adult mental health service users on CPA have had a formal review of their care within the last 12 months.

This measure is no longer reported as part of the single oversight framework to NHS Improvement however it continues to be monitored locally through the combined quality and performance report to the Trust Board. Performance information against this target is available to the clinical teams via the performance dashboard on COGNOS and can be continuously monitored to identify issues and to formulate actions to improve compliance. This information is available at an individual team level.

Figure 21 – CPA formal reviews within 12 months



3.8.1 Ensure that Cardio Metabolic assessment and treatment for people with psychosis is delivered routinely in the following areas: (a) Inpatient wards, (b) early intervention in psychosis services, (c) community mental health services (people on Care Programme Approach).

The Trust's population of service users meeting the national audit inclusion criteria was identified by the Informatics Service. An anonymised list was submitted to the national audit team, based in the Royal College of Psychiatrists. The national team identified a random sample of 50 service users.

Data was gathered on the 50 service users in two stages:

1. The Informatics Service ran a report of data entered on the cardio-metabolic screening tool from PARIS;

2. Clinicians/support staff audited the full health record/Leeds Care Record for evidence of screening and interventions when the cardio-metabolic screening tool was incomplete.

The data collection period was 23 January to 17 March 2017.

The national team provided all participating Trusts with their audit data when data cleansing was completed. The Trust analysed the data in order to understand current practice.

For each measure, compliance is achieved when there is evidence in the health record that:

1. Screening has been completed, or offered and refused, AND
2. Interventions (if indicated by screening) have been offered, or offered and refused.

Table 27 – Analysis of screening and interventions

	Smoking	Alcohol	Substance misuse	Weight/BMI	Blood pressure	Glucose	Cholesterol
Screened	46	46	48	48	46	44	45
No evidence of screening	4	4	2	2	4	6	5
Interventions indicated by screening	27	4	15	28	3	6	0
Interventions offered	27	4	9	19	3	3	0
Measure compliance	92%	92%	84%	78%	92%	82%	90%

NOTE: The compliance rates provided are for each measure. The national team calculate the CQUIN compliance rate, which is usually published on the Royal College of Psychiatrists website towards the end of May, for the previous year. As the 2017 submission data has not yet been published, this will be included in next year's quality report.

Royal College of Psychiatrists – CQUIN Data

Inclusion criteria:

1. Patients who have a diagnosis of psychosis, including schizophrenia and bipolar affective disorder with the relevant ICD-10 diagnostic codes, AND

2. Patients who were inpatients (admitted to a ward for at least seven nights) between 1 August and 30 September 2016.

Table 28 – Inpatient sample per care group 2015-2016

	2016	2015
INPATIENT SAMPLE	**50**	**100**

Care Group	**2016**	**2015**
Leeds Mental Health	33	78
	66%	*78%*
Specialist and Learning Disabilities	17	22
	34%	*22%*

Services by Care Group	
Leeds Mental Health	
Adults and PICU	21
Older People	6
Rehabilitation & Recovery	6
Community Mental Health Teams	0
Total	*33*
Specialist & Learning Disabilities	
Forensics	14
CAMHS	1
LD	2
Total	*17*

The two figures below show rates of compliance for screening and offer of interventions, when indicated, for each of the three cycles of audit.

Figure 22 – Rates of screening

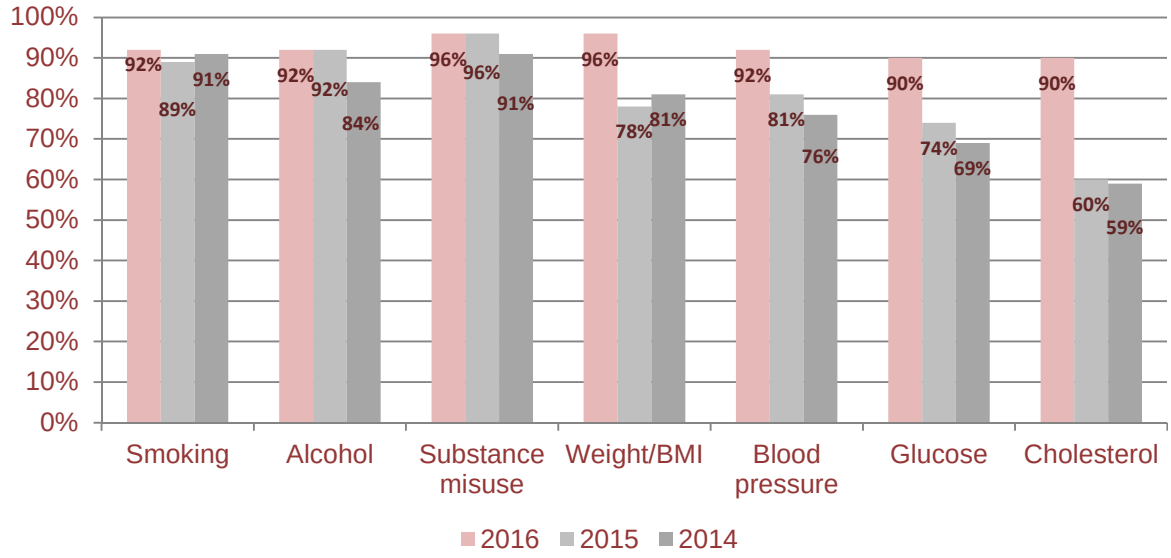
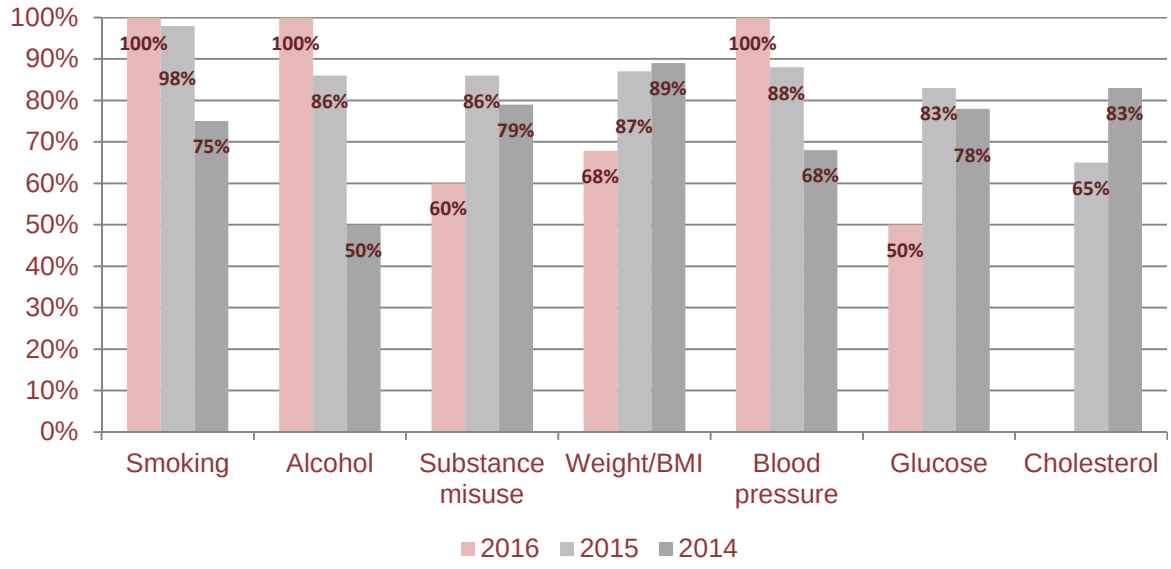


Figure 23 – Rates of offering interventions, when indicated



The Trust's population of service users meeting the national audit inclusion criteria was identified by the Informatics Service. An anonymised list was submitted to the national audit team, based in the Royal College of Psychiatrists. The national team identified a random sample of 100 service users.

Data was gathered on the 100 service users in two stages:

1. The Informatics Service ran a report of data entered on the cardio-metabolic screening tool on PARIS
2. Clinicians/support staff audited the full health record/Leeds Care Record for evidence of screening and interventions when the cardio-metabolic screening tool was incomplete.

The data collection period was 23 January to 17 March 2017.

The national team provided all participating Trusts with their audit data when data cleansing was completed.

The Trust analysed the data in order to understand current practice.

For each measure, compliance is achieved when there is evidence in the health record that:

1. Screening has been completed, or offered and refused, AND
2. Interventions (if indicated by screening) have been offered, or offered and refused.

Table 29 – Table of analysis

	Smoking	Alcohol	Substance misuse	Weight/BMI	Blood pressure	Glucose	Cholesterol
Screened	85	83	91	78	68	86	80
No evidence of screening	15	17	9	22	32	14	20
Interventions indicated by screening	39	9	14	32	10	14	0
Interventions offered	27	6	8	14	7	6	0
Measure compliance	73%	80%	85%	60%	65%	78%	80%

NOTE: The compliance rates provided are for each measure. The national team calculate the CQUIN compliance rate, which is usually published on the Royal College of Psychiatrists website towards the end of May, for the previous year. As the 2017 submission data has not yet been published, this will be included in next year's Quality Report.

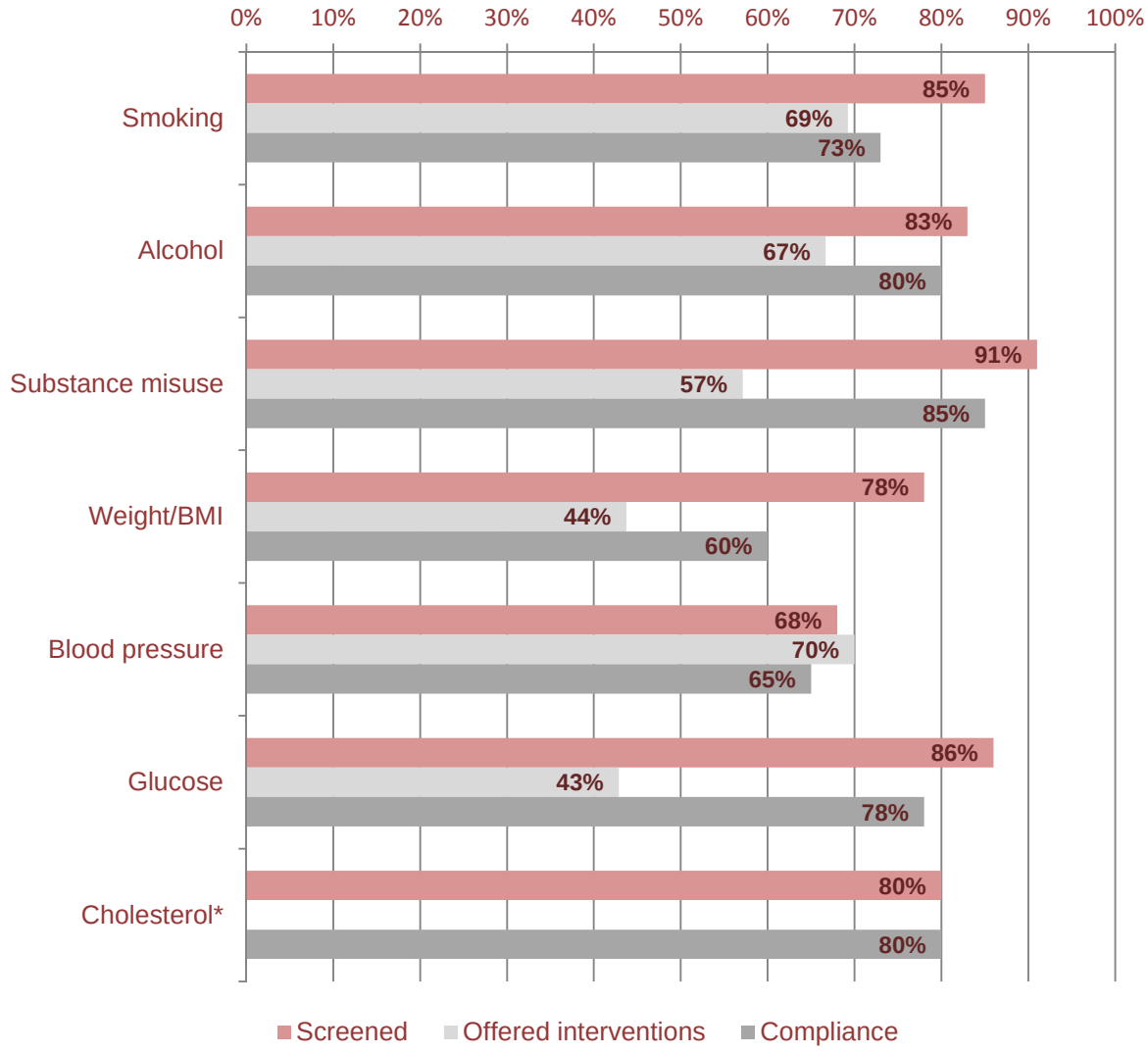
Inclusion criteria:

- Patients who are on Care Programme Approach; and
- Patients who were community patients on the caseload for at least 12 months between 1 August and 30 September 2016; and
- Patients who have a diagnosis of psychosis, including schizophrenia and bipolar affective disorder, with the relevant International Classification of Disease 10 (ICD-10) diagnostic codes.

Compliance by indicator measures:

- 80-89% compliance was achieved for three measures:
  - alcohol
  - substance misuse
  - cholesterol
- 70-79% compliance was achieved for two measures:
  - smoking
  - glucose

Figure 24 – Compliance rates



3.8.2 Admission to adult facilities of patients under 16 years old.

The Trust had no admissions to adult facilities of patients under 16 years old, from 1t April 2017 to 31st March 2018.

3.8.3. The tables and figures below shows the number of inappropriate out of area placements for adult mental health services

Figure 25 – Appropriate and inappropriate out of area admissions

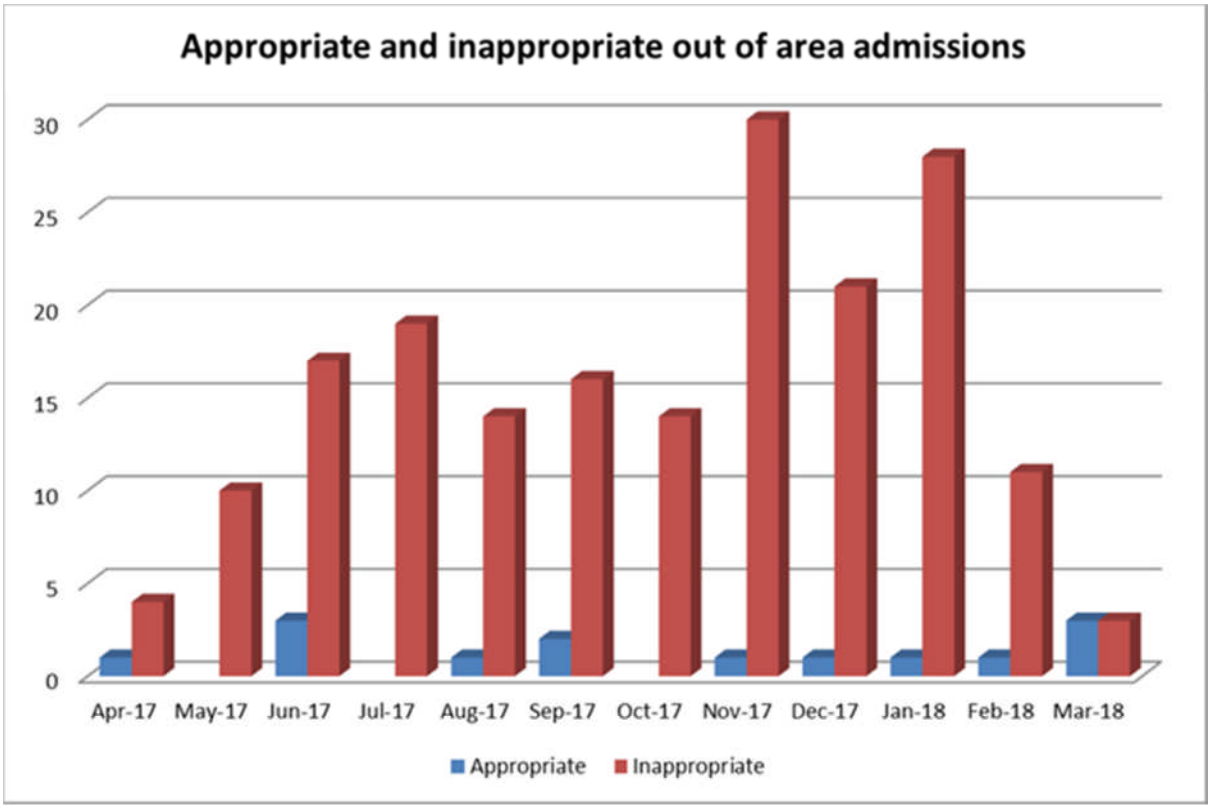


Table 30 – Appropriate and inappropriate out of area admissions

	2017									2018			
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Appropriate	1		3		1	2		1	1	1	1	3	14
Inappropriate	4	10	17	19	14	16	14	30	21	28	11	3	187
Total	**5**	**10**	**20**	**19**	**15**	**18**	**14**	**31**	**22**	**29**	**12**	**6**	**201**

The definition is the average number of inappropriate OOA bed days per month for the period stated. Calculation is the total number of bed days in the period/number of months in the period. This information is shown in the summary table.

Table 31 – Summary of reasons why service users were placed out of area

Referred Out Of Area Reason	10	Unavailability of bed
	11	Safeguarding
	12	Offending restrictions
	13	Staff member or family/friend
	14	Patient choice
	15	Admitted while away from home

An out of area placement may be appropriate when:

- the person becomes acutely unwell when they are away from home (in such circumstances, the admitting provider should work with the person's home team to facilitate repatriation to local services as soon as this is safe and clinically appropriate)
- there are safeguarding reasons such as gang related issues, violence and domestic abuse

- the person is a member of the local service's staff or has had contact with the service in the course of their employment
- there are offending restrictions
- the decision to treat out of area is the individual's choice e.g. where a patient is not from the local area but wants to be near their family and networks.

This list is not exhaustive. There are other reasons why treatment in an out-of-area unit may be appropriate. In these cases discharge and/or return to an appropriate local unit should be facilitated at the earliest point.

An out of area placement that is solely or primarily necessitated because of the unavailability of a local acute bed will not meet the criteria for being appropriate.

Reference: https://www.gov.uk/government/publications/oaps-in-mental-health-services-for-adults-in-acute-inpatient-care/out-of-area-placements-in-mental-health-services-for-adults-in-acute-inpatient-care

3.4.4 Emergency Readmission and Discharges

Tables 32-35 – Number of discharges and emergency readmissions by quarter during 2017-18

	Q1 2017/18		
	Discharges	Emergency Readmissions within 28 Days	Readmission Rate
0-16	2	0	0.0%
16+	462	12	2.6%
Summary	**464**	**12**	**2.6%**

	Q2 2017/18		
	Discharges	Emergency Readmissions within 28 Days	Readmission Rate
0-16	6	0	0.0%
16+	463	29	6.3%
Summary	**469**	**29**	**6.2%**

	Q3 2017/18		
	Discharges	Emergency Readmissions within 28 Days	Readmission Rate
0-16	4	0	0.0%
16+	449	21	4.7%
Summary	**453**	**21**	**4.6%**

	Q4 2017/18		
	Discharges	Emergency Readmissions within 28 Days	Readmission Rate
0-16			
16+	446	21	4.7%
Summary	**446**	**21**	**4.7%**

In the past year we have had no emergency readmission of service users aged 16 years and under. There were no discharges of anyone aged 16 years or under in Quarter 4 and therefore there is no data to report.

We aim to ensure that all service users experience a well-planned and successful discharge from hospital however there is a need to take therapeutic risks with service users and this sometimes results in readmission to hospital within 28 days. The latest benchmarking information that we have for mental health trusts shows an average of 8.8% of emergency readmissions.

3.9 IMPROVING THE QUALITY OF THE TRUST'S SERVICES IN 2017/18

Below is a selection of the work that some of the Trust services have undertaken over the past year to improve the quality of the service they provide. The achievements for 2017/18 have been taken from our 'Imagine' publication.

3.9.1 Our new website is live – April 2017

The new site has been developed with the involvement of service users, carers, staff and stakeholder partners and will offer a more user friendly, accessible and responsive experience for visitors. Visit www.leedsandyorkpft.nhs.uk.

3.9.2 Changes to community mental health services – 1 February 2018

More than 100 staff from across the Leeds Care Group came together for the half-day session on 18 January 2018 to review progress on the Older People's Service (OPS) redesign and be introduced to the Working Age Adult (WAA) redesign.

The current project groups and board have been joined together and are to be rebranded as the Community Model Redesign to reflect the changes to the entire community model.

Board members from the Community Model Redesign gave a presentation to update staff on the review work, recap on the OPS pathways, introduce the WAA pathways for CMHT and CRISTAL (Crisis Resolution Intensive Support Therapeutic Advice and Liaison), and explain the staffing models and updated timeline.

3.9.3 Changes to the Older People's Service redesign – 1 February 2018

The first meetings of both the Service User and Carer Steering Group, and the Project Group were held on 4 April 2017.

Both meetings were an opportunity to set the scene for the redesign, to review the project's progress to date and to plot the next steps in the implementation phase. An update on the Trust's intranet provides the outcomes of these meetings.

Discussions at the first Service User and Carers Group included how the new model could address the language, cultural and stigma barriers that prevent certain groups of older people accessing services, and how we can improve collaboration with other organisations who work with the same client groups that we do.

A commitment to open communication and transparency is one of the project's key priorities.

3.9.4 Other Highlights

3.9.4.1 Trust nurse to speak at European conference European Festival for Psychiatric Nursing – 17 May 2018

Hollie Roblin, Community Mental Health Nurse for our East North East Community Mental Health Team based at St Mary's House, is set to represent the Trust at a conference held in Malta this week.

Hollie will be speaking at the European Festival for Psychiatric Nursing, which starts on Thursday 11th May. The theme of this year's festival is 'Working in Partnership' and is aimed at all professionals working within mental health.

3.9.4.2 Forensic Services Improvement Programme first blog published

Following the external review of the Trust's Forensic Services, a quality improvement team (QI Team) has been set up to oversee an improvement programme.

This includes the implementation of recommendations from the report presented in March 2017 and to oversee quality improvements and address key issues within the service in both Leeds and York.

QI Team member Steven Dilks (Forensics Service Manager) has published the first in a series of regular blogs and briefings on Staffnet about the work he and the team are taking forward

3.9.4.3 Review of Trust governance arrangements - call for staff to join focus groups

The Trust is in the process of reviewing its governance arrangements. The first part of this work has now been completed and the next phase will take place between July and August 2017.

As part of this process, Deloitte would like to hold two focus groups with staff. The aim of these groups is to ask for your views on various aspects of the Trust's governance arrangements, including its vision and future direction, quality of engagement, and views on Board effectiveness and leadership.

The focus groups will take place on Friday 21 July at The Becklin Centre. Group one will meet between 9am and 10.30am and will be for bands 6-8 and group two will meet between 11am and 12.30pm and will be for bands 2-5.

3.9.4.4 Karen Ball is appointed to Royal College of Psychiatrists' Psychiatric Trainees Committee – July 2017

Psychiatrist in training (CT2), Karen Ball, has been appointed as the Yorkshire and Northern Division Committee Trainee Representative on the Royal College of Psychiatrists' (RPsych) Psychiatric Trainee Committee (PTC). The PTC represents psychiatry trainees throughout the UK and is actively involved in many aspects of College project work and policy. Karen was inspired to apply for the role following the appointment of her previous clinical supervisor and Trust Consultant Old Age Psychiatrist, Dr Wendy Burn, as President of RPsych. Karen's new role will last for two years and was confirmed at the College's International Congress in Edinburgh in June.

3.9.4.5 Growth of offenders' service and new funding - Partnership service supporting offenders with personality disorder grows

A partnership between the Trust and the National Probation Service has secured additional funding to ensure offenders with personality disorder receive the care they need. The Yorkshire/Humberside Personality Disorder Partnership (YHPDP) launched in April 2013 and is commissioned on a national basis by NHS England and the National Offender Management Service.

The partnership originally supported probation officers and had a team of eight staff however; over the last four years the team has grown to over 30 people and now supports a wider group including four other services that work directly with service users. The YHPDP Team includes psychologists, psychotherapists, occupational therapists and probation officers.

YHPDP forms part of the Trust's Personality Disorder Service and the team work collaboratively to develop a risk management plan and support service users to seek the most appropriate treatment for their needs.

3.9.4.6 New video to help young people admitted to children's unit

Young people and staff at our child and adolescent mental health service (CAMHS) inpatient unit, Mill Lodge, have worked together to develop a new animated video designed to let future service users know what to expect when staying at the unit.

The video was developed over the course of two weeks and was designed to help future service users feel more prepared for their visit and to reduce any anxiety they may feel about staying on an inpatient ward.

A group of young service users worked with York-based video company, BioAnimation, to build the characters, create the background music, record the voiceover and film the ‘stop motion’ animation that features throughout the video.

The group also worked collaboratively with staff and BioAnimation to write the script for the video, discussing what information they felt a young person would need to know before being admitted on to the unit and ensuring this was presented in a fun and accessible way.

3.9.4.7 Meetings administration - Manual and training available September 2017

The Executive Team has agreed that all our formal meetings will be run in a consistent way and have standardised documents in place to evidence the decisions we make and the actions we take. So you may need to make some changes to the way you operate in accordance with the manual.

We are also running a series of awareness and training sessions for chairs, administrators and members of meetings.

3.9.4.8 Positive feedback for Mill Lodge - five-star rating (NHS Choices)

The Child and Adolescent Mental Health Service (CAMHS) Inpatient Unit at Mill Lodge has received a great review on NHS Choices:

“I have been in a few hospitals around the country. To any parents of patients, or patients themselves, you can be confident that Mill Lodge will provide care for you/your child to help beat any difficulty you are facing at the minute. There are many staff there that really care about the happiness, recovery and future of you/your child. The nurses in particular are fantastic at what they do. My main advice is that if you have a day where you feel more positive, join in with the activities going on around the ward. Chat to the staff, not just when you need help, just generally. Also take up knitting or something creative, it's a great way to pass spare time if you're having a day when you're feeling a bit better. Things sometimes get worse before they get better, remember to try to talk to people when you can, and don't be disheartened if you have a little dip…”

3.9.4.9 Positive feedback for Yorkshire Centre for Eating Disorders (NHS Choices review)

The Yorkshire Centre for Eating Disorders has received a five star rating on NHS Choices from the grandparent of a service user.

Ronald who rated the service, said: "I am the grandparent of Thomas who came to The Newsam Centre earlier this year. He is anorexic. We made a number of visits over the early part of 2017. Then he was allowed to go home in Derbyshire on weekend visits. He has progressed to the extent that he has now been declared sufficiently on target to return home permanently. My wife and I, and Thomas' parents, have been more than pleased with the care and treatment offered to Thomas. We all believe that the staff at the centre and the other patients have all helped Thomas. Many thanks to all involved in the care."

3.9.4.10 Positive feedback for Yorkshire Centre for Eating Disorders (NHS Choices review)

The Yorkshire Centre for Eating Disorders at The Newsam Centre has a received a five star rating on NHS Choices.

Susan and Malcolm, grandparents of a service user, said: “Since being an inpatient in the eating disorder clinic and now permanently at home, we have been delighted with the progress of our adopted granddaughter. We cannot speak highly enough of the staff and the facilities which has led to

an incredible transformation of a young lady who is now healthy, confident and living each day with enthusiasm and energy.

“We have known our adopted granddaughter for many years and could not foresee the time when she would be independent to such a great degree where eating is no longer a major issue. Thank you.”

3.9.4.11 Praise for ‘phenomenal psychiatrist’ (NHS Choices)

A Trust psychiatrist has received excellent praise on NHS Choices from a service user.

The service user wrote: “Having had a trauma and feeling at crisis point, I came in to see a doctor with a somewhat pessimistic expectation. It took one appointment to entirely reverse the stress, crisis and distress. I was allowed to engage honestly, without the constraints of trying to skip around sketchy areas. The doctor I saw was a truly phenomenal Psychiatrist, who absolutely turned my thinking and emotion in the opposite direction. They engaged on my terms, clarified where the problem was and what I could do to protect myself and my wellbeing.

“I now feel there is a light, and they switched it on for me. People like this in this career are rare, few and far between. For the first time I opened up entirely and was able to deal with the problems while they guided me to the solutions. This doctor is almost certainly responsible for saving endless lives and easing a crisis or distress. As I said, words cannot do them justice.”

3.9.4.12 Changes to Community Learning Disability Services in Leeds – 10 April 2018

Changes to community learning disability services in Leeds come into effect from today.

The new look community service aims to improve access for people and reduce waiting times. The Trust has also introduced new criteria for those being referred into the service to ensure people who really need specialist support get it quickly.

3.9.4.13 Clinical Teaching Excellence Award for Dr Ben Alderson

Dr Ben Alderson, a Specialty Trainee in Old Age Psychiatry at our Trust and Leadership Fellow in Quality Improvement Integrating Physical and Mental Health, has received a Clinical Teaching Excellence Award for his work with the University of Leeds medical undergraduate students.

Ben’s recent work within the Trust and medical education has included redesigning teaching sessions within the psychiatry programme by moving away from traditional classroom teaching to a workshop model. He has also developed communication skills events for trainees which have been successfully piloted in Leeds and will be run in Sheffield later this year. These changes have gone towards improving the teaching programme and feedback from the undergraduate students has been very positive.

Ben was also recently named as Yorkshire School of Psychiatry’s Higher Trainee of Year.

3.9.4.14 Positive Practice in Mental Health Awards – October 2017: two of the Trust's services were highly commended at the national awards ceremony

Leeds Personality Disorder Services and the Yorkshire Centre for Eating Disorders were shortlisted for National Positive Practice in Mental Health Awards, in the Specialist Services and Specialist Eating Disorders Care categories respectively.

There are 21 award categories in total, and winners were announced at a ceremony in Blackpool on Thursday 12 October.

Although the services were not winners this year, they were both highly commended.

The awards recognise excellence in mental health services and are organised by the Positive Practice Mental Health Collaborative.

The collaborative consists of 75 organisations, including NHS Trusts, Clinical Commissioning Groups, police forces, third sector providers, charities and service user groups, all committed to identifying and disseminating positive practice, sharing learning and raising the profile of mental health with politicians and policymakers.

3.9.4.15 New SUNRAYS group launched

SUNRAYS groups are designed to bring together people with lived experience of mental health conditions and learning disabilities to improve local services.

Bev Thornton, Recovery and Social Inclusion Worker at Leeds and York Partnership NHS Foundation Trust, said: “The launch of South Leeds SUNRAYS means we will have a Service User Network event at each of our community hubs.

“The South Leeds SUNRAYS group will take place on the third Wednesday of every other month. We hope to see as many service users, their families and carers as possible.”

The first guest speaker will be Julie Poxton, Community Mental Health Team Clinical Lead, who will give an overview of the service and answer any questions.

3.9.4.16 HSJ Award nomination for Trust project - Developing health coaching skills

A project in which the Trust is a key partner has been shortlisted for a HSJ award in the ‘Improved Partnerships between Health and Local Government’ category.

The recognition reflects the Trust’s work with partners across the Leeds health and social care system in supporting the development of health coaching skills, work which has been ongoing for the last three years.

Health coaching includes helping service users to gain the knowledge, skills, tools and confidence to become active participants in their care so that they can reach their self-identified health goals.

Angela Earnshaw, Head of Learning and Organisational Development, and Claire Paul, Healthy Living Services Manager, provide leadership to the project with support from clinicians and staff across the Trust.

Angela Earnshaw said: “The health coaching skills are being put to use by clinicians across the system to support better conversations and enable a joint approach to delivering services.”

There are two health coaching training programmes for Trust staff remaining this year. More details can be found on Staffnet. The winners of the HSJ Awards will be announced on Wednesday 22 November.

3.9.4.17 Trac: new recruitment management system goes live 11 April 2018 - Improving our recruitment process

If you are a recruiting manager then you need to know we are launching a new recruitment management system called Trac on Tuesday 31 October.

Trac will improve our recruitment process for applicants, recruiting managers and our central recruitment team.

It looks and feels a little different to NHS Jobs so we’ve been running training sessions across the Trust to familiarise recruiting managers before going live. There’s also a dedicated Trac page on Staffnet with loads more about the new system and its benefits.

3.9.4.18 Bullying and Harassment – November 2017

In August, more than 500 staff took part in an online conversation and made more than 2000 contributions to help the Trust tackle bullying and harassment. The results of that conversation were considered at the Workforce and Organisational Development Committee meeting in October.

Three actions were agreed at the meeting:

1. to commission the Arbitration Conciliation Advisory Service (ACAS), an independent expert organisation, to review the results of the online conversation and help us to develop an action plan to address the issues

2. to ensure that any bullying and harassment concerns are routinely discussed within teams, and are addressed through regular one to one meetings or supervision. Of course, in some instances this might not be appropriate, in which case you should discuss your concerns with another senior manager, with HR, with your Trade Union representative or with the Freedom to Speak up Guardian. The bullying and harassment procedure includes guidance on incidents involving service users, carers or members of the public, and is available on Staffnet

3. to review and re-launch the 'Dignity at Work' advisor programme. This programme will aim to provide informal and swift resolution to any difficulties through peer support and signposting for staff.

3.9.4.19 Reminiscence boxes - Library and Knowledge Services

The library will be launching reminiscence boxes this month.

The reminiscence boxes aim to improve the wellbeing of service users with dementia or memory problems. Multisensory activities have been proven to be important when engaging with someone who has dementia and the library has a variety of boxes that evoke a number of senses to help staff engage with service users in a therapeutic way.

There are a number of themed boxes available including:

- men's reminiscence box
- women's reminiscence box
- games box
- gardening box
- crafts box

3.9.4.20 Leeds Mental Health Drop-in – December 2017

Professionals from Leeds and York Partnership NHS Foundation Trust, along with partners Touchstone, have joined forces to offer extra support to those living with mental ill health.

Zellany Neal, Creative Practitioner and Dialectical Behaviour Therapist at the Trust, said: "Every Friday afternoon from 12.30pm to 2.30pm, people can visit us in a safe space at the Civic Hall where they can get one-on-one advice from mental health professionals."

At the sessions you can find out more about mental health services, receive advice on how to manage your condition, talk to someone about how you're feeling and get practical support with tasks like arranging hospital appointments or completing forms.

Zellany added: "The drop-in was originally set up to support our service users who were going through discharge from our community mental health teams, but it is open to everyone, whether they're in mental health services or not. We aim to empower people and provide them with the knowledge and tools to manage their own mental wellbeing.

"Some people just come for a cup of tea and a chat and we see people from all walks of life looking for advice. We welcome anyone who wants to talk to someone about their mental wellbeing, whether it's the first time they've spoken about it or they're a service user."

If you'd like to attend the Mental Health Drop-in, there is no need to book, just turn up. It takes place every Friday in room 5 at the Civic Hall in Leeds.

3.9.4.21 New community Eating Disorders service for adults in West Yorkshire and Harrogate

The Trust has launched a recruitment campaign for its new Adult Community Eating Disorders Service.

The new service is being set up following the announcement earlier this year that we were one of 11 pilot sites across England selected to develop new models of care to deliver some of the ambitions set out in the NHS Five Year Forward View.

The new community service would be mainly for the circa 140,000 adults with moderate to severe anorexia nervosa and severe bulimia nervosa across the West Yorkshire and Harrogate Sustainability and Transformation Partnership footprint.

It's being set up by our award-winning Yorkshire Centre for Eating Disorders which currently provides adult eating disorders inpatient services serving a regional population, and a community service for the population of Leeds. The new service will consist of:

- an East Community Team covering Leeds, Harrogate and Wakefield
- a West Community Team covering Bradford, Airedale, Calderdale and Kirklees
- an Inpatient Team based at The Newsam Centre in Leeds serving the whole area.

3.9.4.22 Mind the GAAP: Our Governance, Accountability, Assurance and Performance framework

One of the key issues for staff which we have heard repeatedly through various feedback channels is our governance. In other words, how decisions are made, how to escalate concerns, who is accountable for those decisions and how we use data and information to drive our decision-making.

The decision-making system within the Trust has, over time, evolved in response to various new challenges or requirements and has become confusing, to say the least.

In response to this, Ian Bennett, our Head of Operational Quality and Governance Development, has developed a clear Governance, Accountability, Assurance and Performance (GAAP) framework.

Ian, alongside Cath Hill, our Head of Corporate Governance, will be briefing various management teams on the GAAP in January and February 2018.

3.9.4.23 New year, new look – 4 January 2018: Visual identity refresh

The Trust's Communications Team has just introduced a set of new design rules to make sure that all our external communication looks professional and has been produced to a high standard. Over the coming year, we'll be gradually introducing this new look but we've already made a start with the Trust's magazine, called Imagine, and our refreshed website.

Service users tell us that we have been painting a confusing picture for some time with sub-brands, colour schemes and design styles across our services. Our visual identity refresh will make sure we present a clear, consistent and modern picture of the Trust which reflects our aim to be a high-performing organisation.

Our new visual identity is built on our values: integrity, simplicity and caring. We will be including these on all our public-facing documents and electronic communication.

A group of staff were involved in the development of the new look, with the help of our Service User Network (SUN). This was really valuable as they are the people who understand our services, our people, our history and our future direction.

The refreshed identity will be rolled out across all Trust materials during 2018, using a phased and digital-first approach. Wherever possible we will only have electronic versions of our information, but

when we need to print, we'll make sure stocks of existing printed and offline materials have been used up first so there's no waste.

3.9.4.24 11th Annual Research Forum

Almost 100 people from a range of disciplines attended our 2017 Annual Research Forum in November.

The event showcased the fantastic research and evaluation work completed by our Trust and academic staff. Professor Sue Proctor, the Trust's Chair, opened the day by celebrating the achievements of the past year. This highlighted how the Trust has outperformed in a number of areas including exceeding its recruitment target for the number of people recruited to National Institute for Health Research (NIHR) portfolio research studies.

There were also a number of interactive workshops on offer, looking at new ways of thinking about patient involvement in research; top tips for preparing for research funding and insight into professionals sharing lived experience with service users.

Presentations held throughout the day covered a wide range of topics and included a mix of study outcomes and future research priorities. Outcomes included sharing the much anticipated results of the STEPWISE trial, which examined a weight management programme for people with psychosis.

During the event, 19 posters were displayed and delegates had the opportunity to vote for their top two. After the votes had been counted, the winners were announced:

1st prize
• I-SOCIALISE: Investigating Social Competence and Isolation in children with Autism taking part in LEGO-based therapy Clubs In School Environments (Dr Barry Wright, Danielle Varley, and Ellen Kingsley)

Joint 2nd prize
• Challenging the stigma attached to mental health problems in healthcare professionals and students (Dr Ahmed Hankir and Dr Charlotte Wilson Jones)
• Supporting Service Users through Media: A Survey of Communication, Internet and Social Media use in the Personality Disorder Clinical Network (Aliya Zamir)

After making some changes to the event following feedback from last year, we were delighted to see that 93% of respondents rated the 2017 event as 'very good' or 'excellent'. Visit our website to see the full list of presentations, abstracts and photographs.

3.9.4.24 Research and Development Team race ahead of target – February 2018

Huge congratulations are in order for our colleagues in Research and Development who hit their recruitment target for the financial year nearly four months early!

The team had met its annual target of recruiting 650 people to join research studies by early December covering mental health and dementia as well as the Yorkshire Health Study – an ongoing study following the lives of thousands of people in the county.

The team's recruitment target is set by the National Institute for Health Research but when they reached it they then set their sights even higher, with an aim to recruit 650 people to trials (excluding the Yorkshire Health Study) which they successfully met in early January.

Alison Thompson, Head of Research and Development, said: "We've got a really good team who know what they're doing. We use lots of different strategies and reach out to people in diverse settings which is really paying off.

"We are keen to encourage staff, service users, carers, friends and families to support research not just by taking part but by using their knowledge and experiences."

Pamela Liversidge, who has taken part in a study to see if a common blood pressure drug will slow down the progression of Alzheimer's disease, said: "I was more than happy to help out with the trial. Even if it doesn't help me now it may help someone else in the future. Everyone involved in the trial has been really helpful and made things really easy for me."

The Trust has teams in two locations, with research into adult mental health services and dementia based in Leeds and the Child Oriented Mental Health Intervention Centre (COMIC) in York.

3.9.4.25 New mental health service for armed forces veterans – 5 March 2018

NHS England has chosen our Trust to provide a new mental health service for armed forces veterans in communities from South Yorkshire and Cheshire, right up to the Scottish Borders.

We will provide the new Veterans' Mental Health Complex Treatment Service (VMH CTS) for the north of England, working with the UK's leading charity for veterans' mental health, Combat Stress.

Rollout of the new service, which will increase access to local care and treatment for veterans with complex mental health issues, will begin in early April. It will offer therapies for veterans experiencing psychological trauma (such as post-traumatic stress disorder), alongside a range of other treatments including help with substance misuse, physical health, employment, accommodation, relationships and finances.

3.9.4.26 Rainbow Alliance celebrates one year anniversary – 22 March 2018

New digital presence**.** Today marks one year since the Rainbow Alliance launched.

The Alliance is a network of staff, service users and carers committed to enhancing the quality of services the Trust delivers to the LGBT+ community.

Today we've launched a Rainbow Alliance page on the Trust's website and co-founder, Kate Ward, has penned a blog about what inspired the movement.

3.9.4.27 Spotlight on Autism

It's a wrap on film series to improve our knowledge of the condition.

A series of short films have been created to help us all better understand autism in adults.

Staff at the Leeds Autism Diagnostic Service (LADS) originally wanted to produce the films for busy GPs, but feel the finished videos are relevant for everyone.

"As part of the Autism Act, clinicians who come into contact with people with autism must have an understanding of their needs and be able to respond appropriately," says Alison Stansfield, Clinical Lead and Consultant Psychiatrist at LADS, an autism diagnostic service for adults in Leeds.

"We felt that GPs must be really struggling with all the training they have to do and don't necessarily have much time even if they are interested and want to know more. So, we wanted to create a resource that they could watch quickly, between patients and without leaving their desk."

The films include the experiences and insight of Dr James McGrath, an author and lecturer in English, History and Media at Leeds Beckett University who received his diagnosis from LADS three years ago. They cover topics including the sensory sensitivities associated with autism, the importance of routine for a person diagnosed with autism and the problems that can arise from stereotypes and the way the media portrays autism.

"In making the films, I was very glad to have the opportunity to narrate my own experiences, rather than having them explained on my behalf," says James.

"It's been great to talk about things like sensory issues, because these can be hard for others to understand.

“There was something cathartic in talking about these things and I hope the films will help others to be taken seriously if they feel the need to seek a diagnosis.”

Alison added: “I hope the films will raise awareness of autism and that clinicians will consider whether there are people they are seeing who they may want to refer to specialist services. “I hope it will prompt them to adapt their environments and make small changes to help people with autism access health services. This is something that our Trust is interested in already.”

3.9.4.28 Specialised Supported Living Service providing ‘outstanding’ care

The Trust’s Specialised Supported Living Service has been rated ‘Good’ by the Care Quality Commission (CQC) and ‘Outstanding’ for the care it provides.

The service supports and cares for people with learning disabilities and/or autism in 16 ‘supported living’ settings designed to help them live as independently as possible.

The service was previously rated as Requires Improvement in 2016 but following a visit from CQC inspectors in December 2017 and February 2018, the service has received the following rating in March 2018:

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Outstanding
Is the service responsive?	Good
Is the service well-led?	Good
Overall rating for this service	**Good**

The Trust’s Director of Nursing and Professions, Cathy Woffendin, said: “We’re delighted the service has been recognised as ‘Good’ and ‘Outstanding’ for the care it provides. The feedback we’ve received from the CQC is really positive and it’s inspiring to hear all the great things the inspectors picked up on, especially that our staff are providing an extremely person-centred service.

“One of the highlights for me was that they could see our staff supporting service users to achieve their aspirations like going on their dream holiday and starting new hobbies.”

A team of 200 staff make up the Specialised Supported Living providing direct care and support to adults with learning disabilities. The staff help with personal care, maintaining physical health and developing leisure and social interests.

Gill Galea, Operational Manager for the service, said: “I am immensely proud of the team and service. The feedback from service users is continuously positive and their family and friends speak extremely highly of the staff and the care their loved ones receive. This recognition from the CQC is a testament to the entire team for putting in so much time, hard work and dedication. Being rated Outstanding for care is a credit to all the staff.

ANNEX 1 – THIRD PARTY STATEMENTS

In recognition of our close working with partners, the Trust engaged with and invited comments on the Quality Report from the following stakeholders; governors, commissioners, Healthwatch and the overview and scrutiny committees in Leeds and York.

The responses received are set out in the following pages.

healthwatch
Leeds

Ground Floor
Old Gipton Fire Station
Gipton Approach
Gipton
Leeds
LS9 6NL

Healthwatch Leeds Quality Account Comments

The QA is comprehensive and demonstrates the range of activity undertaken to improve quality over the last year. Following on from our comments last year we are pleased to note the work that was carried out to promote and improve equality, diversity and inclusion for Black and Minority Ethnic (BME) service users. The work around staff training and development, learning reviews and how you have demonstrated learning and actions taken from this, is also to be commended.

It is positive to see examples of service users feedback within the report, alongside the Trust's clear aim to increase engagement activity in 2018-19. HWL would want to see further evidence of early user engagement in service change moving forward, building on the current work of the Service User and Carers Steering group.

There was a plan for an accessible summary of this report to be provided last year, but we have not seen one. Hopefully this can be provided for this current Quality Account.

Stuart Morrison
Team Leader

Community Interest Company number: 9542077

NHS
Leeds
Clinical Commissioning Group

Ms Cathy Woffendin
Director of Nursing
Leeds & York Partnership NHS Foundation Trust
Trust Headquarters
Thorpe Park
Leeds
LS15 8ZB

03 May 2018

Dear Cathy,

Thank you for providing the opportunity to feedback on the Quality Report for Leeds & York Partnership NHS Foundation Trust 2017-18.

This report has been shared with key individuals across the newly formed Leeds Clinical Commissioning Group (formerly Leeds West CCG, North CCG and South & East CCG) and this response is on behalf of the new organisation.

We acknowledge that the report you provided is in draft form and additional information will be added and amendments made before final publication. In addition there was a very short timescale given for review and comment and we hope to be able to complete this more fully in future by having a more realistic timeframe to adequately review. Please accept our observations of your report on that basis.

We are pleased to see that the Trust has engaged with staff, carers and service users and consulted these groups on the quality priorities and incorporated their views and input into quality improvement. We also note the number of people who have attended the service users' network and the intention to further increase this. The service user feedback is useful to understand the difference services are making to people's lives and the nominations for national awards for Personality Disorder and Eating Disorder services is a great achievement. The success of increased numbers of service users finding employment through the partnership vocational support model is also to be applauded.

It is encouraging to see the that the Trust holds 'you said we did' community groups, however it would be useful to include what service or patient experience improvements have been made as a result.

NHS Leeds Clinical Commissioning Group
Suites 2–4, WIRA House, West Park Ring Road, Leeds, LS16 6EB
T: 0113 843 5470 W: www.leedsccg.nhs.uk facebook.com/nhsleeds @nhsleeds

We note the good intention and initiatives to improve engagement with staff including Director 'back to the floor' visits and conversations with the CEO and we congratulate the trust for achieving a target of 85% locally and Trust wide for Clinical supervision.

We hope the improvements seen in the staff survey continue to show positive returns and we welcome the Trusts approach to celebrating staff achievements. The safer staffing steering group is welcomed and we will be keen to review the outputs of this group.

The report is quite long and uses a high number of acronyms throughout. It is also very detailed in places, particularly in relation to last year's priorities and the NICE compliance sections. This distracts from the positive messages of the work being done as it makes it quite complex to navigate. However the work being done to improve the Trust's NICE compliance processes is welcomed.

In contrast some areas would benefit from more detailed explanations such as the use of DemQol and the interpretation of the scores in order for the reader to fully understand the impact.

The implementation of the Leeds Suicide Plan and the STP plan is welcomed but it is disappointing to note that the Trust does not appear to have a local suicide reduction plan that builds on the wider strategic plans. The suicide prevention work needs to develop the Trust approach and identify how it feeds into the Leeds and STP approach.

We congratulate the trust on the development and delivery of a local version of the NHS Leadership Academy's Mary Seacole Programme, aimed at leadership behaviours and impact. We also acknowledge the commitment made to apprenticeships. In addition the Trust's commitment to the associate nurse apprentices and a variety of skills based training programmes delivered to clinical and non-clinical support staff is welcomed.

It is pleasing to see the recent changes to provide a supportive compassionate approach to incident investigations, with the introduction of "Learning Reviews", and enabling teams to be more reflective with regards to lessons learnt. We welcome the inclusive approach to ensure learning is not remote from the clinical teams and ownership of shared learning is promoted. We look forward to receiving feedback from the new approaches taken.

NHS Leeds Clinical Commissioning Group
Suites 2–4, WIRA House, West Park Ring Road, Leeds, LS16 6EB
T: 0113 843 5470 W: www.leedsccg.nhs.uk facebook.com/nhsleeds @nhsleeds

It is disappointing to see the number of Information Governance breaches reported during 2017/18, however we recognise the Trusts commitment to make this a key priority for improvement in 2018/19 and we look forward to seeing progress reported throughout the year.

We acknowledge the work that the Trust has implemented during 2017/18 with regards to reporting, investigating and learning from deaths in care in line with the National Quality Board's guidelines. We are pleased to note the decision to undertake weekly reviews of deaths. In addition the work around Duty of Candour is to be commended and we will look forward to receiving the revised policy.

We recognise the efforts made with the Mental Health Safety Thermometer and congratulate the trust on achieving 100% harm free on a number of wards/services, and 80% harm free on a further 17 services . The safety thermometer work is in its early stages and it will be good to receive future reports on the work undertaken.

We note the overall increase in complaints as compared with 2016/17. However we recognise the investment made within complaints management training, and appreciate the trust's efforts in facilitating training in the handling of complaints for staff. The involvement of the SUN is laudable and the support offered by the SUNRAYS group will surely be welcomed by those with lived experience and offer them a valuable source of support. These groups will also help shape the experience feedback received by the Trust.

It is surprising that the report doesn't contain a section on safeguarding adults or children; training or activity, given the Trust's patient cohort which does have added risks in specific areas.

It is good to see a wide range of local audits included in the account with actions and learning, but it is not clear how progress with the implementation of learning will be monitored. It is crucial there is an overarching mechanism to ensure this is embedded.

There is also a positive focus on research quality and the activity in research is to be congratulated, particularly the work with Alzheimers disease. It is noted that attracting the

NHS
Leeds
Clinical Commissioning Group

required number of people for research initiatives was achieved ahead of timescale and is therefore a successful step in the process.

Other areas of notable work that we are pleased to acknowledge include addressing equality for BME groups, the redesign of older peoples services and the mental health drop in service, all of which we look forward to receiving updates on throughout the coming year.

We would like to acknowledge the Specialised Supported Living Service and say congratulations to the Trust for achieving an 'Outstanding' rating from the CQC for the caring domain within the overall 'Good' rated report.

We are supportive of the quality priorities for improvement for 2017-19, particularly the work to develop the Trust as a rewarding and supportive place to work. Some priorities are very service redesign based and difficult to assess where key deliverables are not yet agreed. However we appreciate the approach and ambitions for improvement in 2018/19.

We welcome the opportunity to review the report, which throughout demonstrates a culture of respect for the service users, and we hope that this is accepted as a fair reflection. We look forward to seeing the progress made over the coming year.

Yours sincerely,

Jo Harding
Executive Director of Quality and Safety/Governing Body Nurse

cc: Dr Simon Stockill, Medical Director

NHS Leeds Clinical Commissioning Group
Suites 2–4, WIRA House, West Park Ring Road, Leeds, LS16 6EB
T: 0113 843 5470 W: www.leedsccg.nhs.uk facebook.com/nhsleeds @nhsleeds

ANNEX 2 – STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE QUALITY REPORT

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust annual reporting manual 2017/18 and supporting guidance
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period 1 April 2017 to 24 May 2018
    - papers relating to quality reported to the Board over the 1 April 2017 to 24 May 2018
    - feedback from commissioners dated 3 May 2018
    - feedback from Governors dated 15 May 2018 (verbal feedback given during stakeholder meeting)
    - feedback from local Healthwatch organisations dated 14 May 2018
    - feedback from the Leeds overview and scrutiny committee requested on 22 May 2018
    - the Board receives regular complaints reports throughout the year, and the annual complaints report, published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, will be received and signed off at 24 May Board meeting.
    - the Mental Health Inpatient survey published on the 2 October 2017
    - the Mental Health Community Service Users survey published on the 2 August 2017
    - the national staff survey dated the 6 March 2018
    - the Head of Internal Audit's annual opinion over the Trust's control environment dated 21 May 2018
    - CQC inspection report dated 24/04/2018
- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- The performance information reported in the Quality Report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review

- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

Date: 24 May 2018  Chairman (Prof Sue Proctor)

Date: 24 May 2018  .. Chief Executive (Dr Sara Munro)

KPMG

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF LEEDS & YORK PARTNERSHIP NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of Leeds & York Partnership NHS Foundation Trust to perform an independent assurance engagement in respect of Leeds & York Partnership NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the following two national priority indicators (the indicators):

- inappropriate out-of-area placements for adult mental health services
- 100% enhanced Care Programme Approach (CPA) patients receiving follow-up contact within seven days of discharge from hospital.

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the *Detailed requirements for quality reports for foundation trusts 2017/18* ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the *Detailed Requirements for external assurance for quality reports for foundation trusts 2017/18.*

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes and papers for the period 1 April 2017 to 24 May 2018;
- papers relating to quality reported to the board over the period 1 April 2017 to 24 May 2018;
- feedback from commissioners, dated 3 May 2018;
- feedback from governors, dated 15 May 2018;
- feedback from local Healthwatch organisations, dated 14 May 2018;
- feedback from Overview and Scrutiny Committee requested 22 May 2018;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the Mental Health Inpatient survey published on the 2nd October 2017

- the Mental Health Community Service Users survey published on the 2nd August 2017;
- the national staff survey, dated 6th March 2018;
- Care Quality Commission Inspection, dated 24 April 2018;
- the 2017/18 Head of Internal Audit's annual opinion over the trust's control environment, dated 21 May 2018; and
- any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Leeds & York Partnership NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Leeds & York Partnership NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement

techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Leeds & York Partnership NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

KPMG LLP
Chartered Accountants
1 Sovereign Square
Sovereign Street
Leeds
LS1 4DA

25 May 2018

PART C
ANNUAL ACCOUNTS
2017/18

Independent auditor's report

to the Council of Governors of Leeds & York Partnership NHS Foundation Trust

. REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

1. Our opinion is unmodified

We have audited the financial statements of Leeds & York Partnership NHS Foundation Trust ("the Trust") for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers Equity, Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion:

— the financial statements give a true and fair view of the state of the Trust's affairs as at 31 March 2018 and of its income and expenditure for the year then ended; and

— the Trust's financial statements have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, the NHS Foundation Trust Annual Reporting Manual 2017/18 and the Department of Health Group Accounting Manual 2017/18.

Overview	
Materiality: financial statements as a whole	£2.5m 1.6% of operating income
Risks of material misstatement	
Risks	Valuation of land and buildings
	Recognition of NHS and non-NHS income

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

2. Key audit matters: our assessment of risks of material misstatement

Key audit matters are those matters that, in our professional judgment, were of most significance in the audit of the financial statements and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by us, including those which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. In arriving at our audit opinion above, the key audit matters, in decreasing order of audit significance, were as follows :

	The risk	Our response
Valuation of land & buildings (£41.4 million; 2016/17: £50.3m) *Refer to the Audit Committee Report within the 'Board of Directors' Report' in the Trust's Annual Report and Accounts, Section 1.6.1 of Note 1 to the Accounts (accounting policies) and Note 14 to the accounts (Property, Plant & Equipment disclosures).*	**Subjective Valuation** Land and buildings are required to be held at fair value. The Trust's main land and buildings relate to operational hospitals and medical centres in Leeds. As hospital buildings are specialised assets and there is not an active market for them they are valued on the basis of the cost to replace them with an equivalent asset. When considering the cost to build a replacement asset the Trust consider whether the asset would be built to the same specification or in the same location. Assumptions about changes to the asset must be realistic. Generally valuations should be gross of VAT. However, circumstances may arise where the asset would be more appropriately valued net of VAT. For instance, entities may recover VAT on payments for the provision of a fully managed and serviced building under a PFI. The valuation of the land & buildings is completed by the District Valuer, an external expert engaged by the Trust, using construction indices and so accurate records of the current estate are required. Full valuations are required to be completed every five years, with interim desktop valuations completed in interim periods. Valuations are inherently judgmental, therefore our work focused on whether the valuer's methodology, assumptions and underlying data, are appropriate and correctly applied. Leeds & York Partnership NHS Foundation Trust last had a full valuation undertaken at 31 March 2016. The desktop valuation undertaken in 2017/18 resulted in a downward loss of £8 million in the value of the land & buildings.	Our procedures included: — **Assessing valuer's credentials:** We critically assessed the scope, qualifications and experience of the Trust's external valuer to confirm they were appropriately experienced and qualified to undertake the valuation, and we considered whether the overall valuation methodology was in line with industry practice, the Department of Health. Group Accounting Manual and the Trust's accounting policies; — **Data comparisons:** We considered whether the information provided to the valuer by the Trust, relating to the assets requiring to be valued, including details of in-year capital expenditure, changes in use and land area and floor space, was complete and agreed to the Trust's fixed asset records; — **Methodology choice:** We critically assessed the appropriateness of the assumptions used in the valuer's calculations, especially cost indices and underlying replacement cost assumptions, based on our own expectations by reference to sector and local knowledge; — **Assessing transparency:** We critically assessed the treatment of the revaluation within the Trust's financial statements to ensure that any upwards revaluations or impairments had been properly classified and accounted for and complied with the requirements of the Group Accounting Manual; and — **Tests of detail:** We tested a sample of items of capital expenditure in 2017/18 to confirm that the additions were appropriately valued in the financial statements. — **Assessing transparency:** We assessed the disclosures relating to the valuation of Property, Plant & Equipment for compliance with the Group Accounting Manual.

2. Key audit matters: our assessment of risks of material misstatement

	The risk	Our response
NHS and non-NHS income (£156.5 million; 2016/17: £153.3m) *Refer to the Audit Committee Report within the 'Board of Directors' Report' in the Trust's Annual Report and Accounts, Section 1.3 of Note 1 to the Accounts (accounting policies) and Notes 3 and 4 to the accounts (Revenue from Patient Care Activities and Other operating revenue disclosures).*	**Recognition of NHS and non-NHS income:** The main source of income for the Trust is the provision of mental healthcare services to the public under contracts with NHS commissioners, which make up over 93% of income from activities. Income from NHS England and CCGs is captured through the Agreement of Balances exercises performed at months 6, 9 and 12 to confirm amounts received and owed. Mismatches in income and expenditure, and receivables and payables are recognised by the Trust and its counterparties to be resolved. Where mismatches cannot be resolved they can be reclassified as formal disputes.	Our procedures included: — **Tests of details**: We undertook the following tests of detail: — We compared the actual income received from the Trust's CCG commissioners against the contracts agreed at the start of the year. We agreed any significant variations between the actual income and the agreed contract to signed contract variations and other correspondence agreement the variation to the contract**;** — We critically assessed the output from the Department of Health's Agreement of Balances exercise. We obtained evidence and explanations regarding the Trust's recognition of their income, where the output indicated the Trust's income was not matched by corresponding expenditure in other NHS organisations' accounts; — We agreed the receipt and recognition of Sustainability and Transformation Funding monies to correspondence from NHS Improvement; — We agreed a sample of other income to supporting documentation to assess whether the income was correctly recognised in 2017/18; — We agreed a sample of income received in March and April 2018 to supporting documentation to assess whether the income had been accounted for in the correct financial year.

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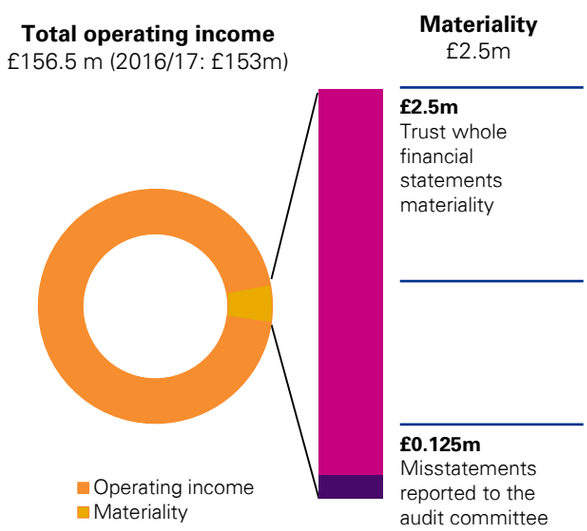
3. Our application of materiality

Materiality for the Trust financial statements as a whole was set at £2.5 million, determined with reference to a benchmark of total operating income (of which it represents approximately 1.6%). We consider operating income to be more stable than a surplus or deficit-related benchmark.

We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £0.125 million, in addition to other identified misstatements that warranted reporting on qualitative grounds.

Our audit of the Trust was undertaken to the materiality level specified above with the exception of the audit of the part of the remuneration report required to be audited, these were audited to a materiality level of £2,500. The audit was all performed at the Trust's headquarters in Leeds.



4. We have nothing to report on going concern

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least twelve months from the date of approval of the financial statements. We have nothing to report in these respects.

5. We have nothing to report on the other information in the Annual Report

The directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information.

In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements

Remuneration report

In our opinion the part of the remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2017/18.

Corporate governance disclosures

We are required to report to you if:

— we have identified material inconsistencies between the knowledge we acquired during our financial statements audit and the directors' statement that they consider that the annual report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Trust's position and performance, business model and strategy; or

— the section of the annual report describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee; or

— the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

We have nothing to report in these respects.

6. Respective responsibilities

Accounting Officer's responsibilities

As explained more fully in the Statement of the Chief Executive's Responsibilities, the Accounting Officer is responsible for: the preparation of financial statements that give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

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KPMG

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

We have nothing to report on the statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

— any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.

— any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

We have nothing to report in respect of our work on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources

Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of resources .

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Report on our review of the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by guidance issued by the C&AG under Paragraph 9 of Schedule 6 to the Local Audit and Accountability Act 2014 to report on how our work addressed any identified significant risks to our conclusion on the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources. The 'risk' in this case is the risk that we could come to an incorrect conclusion in respect of the Trust's arrangements, rather than the risk of the arrangements themselves being inadequate.

We carry out a risk assessment to determine the nature and extent of further work that may be required. Our risk assessment includes consideration of the significance of business and operational risks facing the Trust, insofar as they relate to 'proper arrangements'. This includes sector and organisation level risks and draws on relevant cost and performance information as appropriate, as well as the results of reviews by inspectorates, review agencies and other relevant bodies.

The significant risks identified during our risk assessment are set out overleaf together with the findings from the work we carried out on each area.

Significant Risk	Description	Work carried out and judgements
Financial Sustainability	As part of our responsibilities in relation to reaching our use of resources conclusion we are required to perform any work that we regard as necessary to allow us to conclude on whether the Trust has effectively, efficiently and economically exercised its functions. Due to the significant financial challenge in the sector we have undertaken a detailed consideration of the financial position and financial sustainability.	Our work included: **Financial Sustainability:** We assessed the Trust's financial sustainability. This considered whether the financial results included significant non-recurring items of income within the reported headline result. We also considered the Trust's management of its cash position and delivery of CIPs through the year. **Future forecasts:** We reviewed the future financial forecasts for the Trust. This included: • Performing an analysis of the Trust's forecast run rate position; • Considering the core assumptions in the Trust's 2018/19 Annual Plan submission; • Considering the extent to which recurrent cost improvement schemes were achieved in 2017/18 and identified for 2018/19; and • Reviewing contracts with commissioners which have been agreed for 2018/19 and the supporting risk analysis reported to the Board. **Findings from our work:** • Our work has confirmed that the Trust has adequate arrangements to deliver financial sustainability.
Response to Care Quality Commission (CQC) inspection	The Trust was subject to a Care Quality Commission inspection during January 2018. The report was published on 27 April 2018 and concluded an overall rating of 'Requires Improvement'. This was the third successive 'requires improvement' rating for the Trust. The CQC conclusion on whether the Trust's services were Well-Led was 'Good', and their conclusions on whether services 'are caring' and 'are responsive' were also 'Good'. The conclusions on whether services were 'safe' and 'effective' were that they 'required improvement'.	Our work included: **Reviewing the CQC report:** We reviewed the CQC report and considered whether there were any weaknesses reported which resulted in 'inadequate' ratings. We considered whether the inspection identified any underlying issues in risk management, governance, or decision making. Our work identified that the areas which led to the 'requires improvement' rating were in the 'safe' and 'effective' categories. The 'well led' category moved from 'requires improvement' in 2016 to 'good' at this inspection. Although there are reported weaknesses in some arrangements at the Trust none of these result in an 'inadequate' rating across any category or sub category. The inspection did not identify any underlying issues such as in risk management. **Reviewing the Trust's process to develop an improvement plan to respond to the CQC report**: We reviewed the plan developed following the 2016 inspection and found that all areas identified in the inspection report were included in the plan, with appropriate actions. We reviewed an updated plan which was reported during 2017/18 and confirmed that this showed this also included all areas identified in the 2016 inspection report. We reviewed the Trust's arrangements to respond to the April 2018 CQC report and did not identify any areas of weakness. **Reviewing the Trust's process to monitor and report on progress:** We reviewed the Trust's monitoring and reporting during 2017/18, and considered the Trust's plans for monitoring and reviewing the 2018 CQC inspection Action Plan. We confirmed that the Trust's arrangements through 2017/18 were adequate, including reporting to the 'CQC Fundamentals Group' and Board on the progress on the CQC Action Plans. We also confirmed that the Trust's plans for the current 2018 CQC inspection Action Plan will include the same approach as has operated through 2017/18.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006 and the terms of our engagement by the Trust. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report, and the further matters we are required to state to them in accordance with the terms agreed with the Trust, and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Leeds & York Partnership NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

Rashpal Khangura
for and on behalf of KPMG LLP (Statutory Auditor)

Chartered Accountants
1 Sovereign Square, Sovereign Street,
Leeds, LS1 4DA
25 May 2018

FOREWORD TO THE ACCOUNTS

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

These accounts, for the year ended 31 March 2018, have been prepared by Leeds and York Partnership NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed:  (Chief Executive)

Name: Dr Sara Munro

Date: 24 May 2018

STATEMENT OF COMPREHENSIVE INCOME AS AT 31 March 2018	note	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Operating income	2, 3 & 4	156,513	153,332
Operating expenses	2 & 5	(148,387)	(143,896)
OPERATING SURPLUS		**8,126**	**9,436**
FINANCE COSTS			
Finance income	10	136	130
Finance expense - financial liabilities	12	(3,954)	(3,930)
Finance expense - unwinding of discount on provisions	25	(4)	(23)
PDC dividend payable		(450)	(423)
NET FINANCE COSTS		**(4,272)**	**(4,246)**
Gains (losses) on disposal of assets	11	**(32)**	
Surplus from operations		3,822	5,190
SURPLUS FOR THE YEAR		**3,822**	**5,190**
Other comprehensive income			
Items that will not be reclassified to income or expenditure:			
Revaluation gains and (impairment losses) on intangible assets		(16)	1
Revaluation gains and (impairment losses) on property, plant and equipment		(3,967)	1,593
Other comprehensive income for the year		**(3,983)**	**1,594**
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**(161)**	**6,784**

The notes on pages 14 to 42 form part of this account.

STATEMENT OF FINANCIAL POSITION AS AT 31 March 2018	note	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Non-current assets			
Intangible assets	13	647	629
Property, plant and equipment	14	41,422	50,259
Trade and other receivables	17	4,324	3,937
Total non-current assets		**46,393**	54,825
Current assets			
Inventories	16	64	46
Trade and other receivables	17	6,717	7,632
Non-current assets for sale	19	440	
Cash and cash equivalents	18	52,424	47,737
Total current assets		**59,645**	55,415
Current liabilities			
Trade and other payables	20	(10,278)	(12,253)
Borrowings	21	(1,736)	(1,602)
Provisions	25	(2,092)	(2,732)
Other liabilities	22	(1,226)	(969)
Total current liabilities		**(15,332)**	(17,556)
Total assets less current liabilities		**90,706**	92,684
Non-current liabilities			
Borrowings	21	(21,416)	(23,152)
Provisions	25	(1,961)	(2,041)
Total non-current liabilities		**(23,377)**	(25,193)
Total assets employed		**67,329**	67,491
Financed by (taxpayers' equity)			
Public dividend capital		19,569	19,569
Revaluation reserve		5,784	10,446
Other reserves		(651)	(651)
Income and expenditure reserve		42,627	38,127
Total taxpayers' equity		**67,329**	67,491

The notes on pages 14 to 42 form part of this account.

The accounts on pages 1 to 36 were approved by the Board on 24 May 2018 and signed on its behalf by:

Signed:  (Chief Executive)

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY	Public Dividend Capital £000	Revaluation Reserve £000	Other Reserves £000	Income and Expenditure Reserve £000	Total Taxpayers Equity £000
Taxpayers' equity at 1 April 2017	19,569	10,446	(651)	38,127	67,491
Surplus for the year				3,822	3,822
Revaluation gains and impairment losses on intangible assets		(16)			(16)
Revaluation gains and impairment losses property, plant and equipment		(3,967)			(3,967)
Public dividend capital received					
Transfers to the income and expenditure account in respect of assets disposed of					
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve		(679)		679	
Movement in year subtotal		**(4,662)**		**4,501**	**(161)**
Taxpayers' equity at 31 March 2018	19,569	5,784	(651)	42,627	67,329

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY	Public Dividend Capital £000	Revaluation Reserve £000	Other Reserves £000	Income and Expenditure £000	Total Taxpayers Equity £000
Taxpayers' equity at 1 April 2016	19,569	9,242	(651)	32,547	60,707
Surplus for the year				5,190	5,190
Revaluation gains and impairment losses on intangible assets		1			1
Revaluation gains and impairment losses property, plant and equipment		1,593			1,593
Public dividend capital received					
Transfers to the income and expenditure account in respect of assets disposed of		(3)		3	
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve		(387)		387	
Movement in year subtotal		**1,204**		**5,580**	**6,784**
Taxpayers' equity at 31 March 2017	19,569	10,446	(651)	38,127	67,491

Description of Reserves:

a) Public dividend capital represents in substance, the Secretary of State for Health's 'equity' investment in the Trust. When the Trust's predecessor NHS Trust was established, the amount of PDC provided to it equated to the initial net assets of the Trust. The PDC balance is usually a constant amount but can change occasionally where the Trust receives additional PDC (usually to fund capital investment) or is asked to repay an element to the Secretary of State.

b) The revaluation reserve is used to record revaluation gains/losses and impairment reversals on property, plant and equipment that are recognised in other comprehensive income. An annual transfer is made from the reserve to retained earnings of amounts representing the excess of current cost depreciation over historic cost depreciation for each item of PPE. When an asset is sold or otherwise disposed of, any remaining revaluation reserve balance for the asset is transferred to Retained Earnings. The balance in the reserve is wholly in respect of property, plant and equipment.

c) Other reserves relates to the write off of an asset which was included in the original NHS Trust's asset base at inception.

d) The Trust's surplus or deficit for the year is recognised in the Income and Expenditure Reserve, together with any other gain or loss for the financial year that is not recognised in any other reserve.

The notes on pages 14 to 42 form part of this account.

STATEMENT OF CASH FLOWS AS AT 31 March 2018	note	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Cash flows from operating activities			
Operating surplus from continuing operations		8,126	9,436
Operating surplus		**8,126**	**9,436**
Non-cash income and expense:			
Depreciation and amortisation	5	4,543	4,081
Impairments and reversals	14	1,557	(352)
(Increase)/decrease in trade and other receivables	17	592	(827)
(Increase)/decrease in inventories	16	(18)	(10)
Increase/(decrease) in trade and other payables	20	(1,407)	(4,265)
Increase/(decrease) in other liabilities	22	257	(291)
Increase/(decrease) in provisions	25	(724)	1,893
NET CASH GENERATED FROM OPERATIONS		**12,926**	**9,665**
Cash flows from investing activities			
Interest received	10	122	127
Purchase of intangible assets	13	(154)	(180)
Purchase of property, plant and equipment	14	(2,144)	(2,376)
Sales of property, plant and equipment		5	376
Net cash used in investing activities		**(2,171)**	**(2,053)**
Adjustment for net assets de-recognised on merger			
Cash flows from financing activities			
Public dividend capital received			
Capital element of private finance initiative obligations	21	(1,592)	(1,469)
Interest element of private finance initiative obligations	12	(3,953)	(3,934)
PDC dividend paid		(523)	(440)
Net cash used in financing activities		**(6,068)**	**(5,843)**
Increase/(decrease) in cash and cash equivalents		4,687	1,769
Cash and Cash equivalents at 1 April		47,737	45,968
Cash and Cash equivalents at 31 March		**52,424**	**47,737**

Reconciliation of Statement of Financial Position to working balances adjustment in Cash Flow	2017/18 £000s	2016/17 £000s
(Increase)/decrease in receivables as per SOFP	528	(454)
Adjustments for receivables movements not related to I&E:		
- Increase/(decrease) in capital receivables		(376)
- Financing transactions	64	3
(Increase)/decrease in receivables adjusted for non-I&E items	592	(827)
Increase/(decrease) in payables per SOFP	(1,975)	(3,353)
Adjustments for payables movements not related to I&E:		
- (Increase)/decrease in capital payables	557	(923)
- Financing transactions	11	11
Increase/(decrease) in payables adjusted for non-I&E items	(1,407)	(4,265)
Increase/(decrease) in Other Liabilities per SOFP	257	(291)
Adjustments for Other Liabilities movements not related to I&E:		
Increase/(decrease) in Other Liabilities adjusted for non-I&E items	257	(291)
Increase/(decrease) in provisions per SOFP	(720)	1,916
Adjustments for provisions movements:		
- Unwinding of discount on provisions	(4)	(23)
Increase/(decrease) in provisions for non I&E items	(724)	1,893
Opening capital payables	(1,242)	(319)
Capital payable written off	(171)	
Closing capital payables	(685)	(1,242)
Change in capital payables in-year	**386**	**(923)**

The notes on pages 14 to 42 form part of this account.

Notes to the accounts

The principal activity of the Trust is to provide excellent quality mental health and learning disability care that supports people to achieve the very best that they can for their health and wellbeing. The Trust's registered address is 2150 Century Way, Thorpe Park, Leeds LS15 8ZB.

1 Accounting policies

NHS Improvement (NHSI), in exercise of the powers conferred on Monitor has directed that the accounts of NHS foundation trusts shall meet the accounting requirements of the Department of Health Group Accounting Manual (DH GAM), which shall be agreed with HM Treasury. Consequently, the following accounts have been prepared in accordance with the 2017/18 DH GAM issued by the DH. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS), in accordance with EU endorsed IFRS and IFRIC, and HM Treasury's Financial Reporting Manual (FReM) to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently, other than where new policies have been adopted, in dealing with items considered material in relation to the accounts.

In accordance with IAS1, the accounts are prepared on a going concern basis unless management either intends to apply to the Secretary of State for the dissolution of the NHS foundation trust without the transfer of the services to another entity, or has no realistic alternative but to do so.

Where management are aware of material uncertainties in respect of events or conditions that cast significant doubt upon the going concern ability of the NHS foundation trust, these have been disclosed.

1.1 Accounting convention

The accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment and intangible assets. For specialised operational property the modern equivalent asset valuation method has been used.

1.2 Segmental reporting

Operating segments are reported in a manner consistent with the internal reporting provided to the chief operating decision maker. The chief operating decision maker, who is responsible for allocating resources and assessing performance of the operating segments, has been identified as the Board of Directors.

1.3 Income recognition

Income is accounted for by applying the accruals convention. The main source of income for Leeds and York Partnership NHS Foundation Trust is from commissioners in respect of healthcare services provided under local agreements (NHS Contracts). Where income is received for a specific activity, which is to be delivered in the following financial year, that income is deferred. Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.4 Expenditure on employee benefits

Short term employee benefits

Salaries, wages and employment related payments such as social security and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the accounts to the extent that employees are permitted to carry-forward leave into the following year.

1.5 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

Employers pension cost contributions are charged to operating expenses as and when they become due. Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

In order that the defined benefit obligations recognised in the accounts do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

1.5 Pension costs (continued)

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates payable by employers and employees.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

Employers and employee contribution rates may be varied from time to time, as above, to reflect changes in the scheme's liabilities. In 2017/18 employee contributions are tiered depending on salary and range from 5% to 14.5%. Employer contributions for 2017/18 were 14.38%, including the administration levy (14.3% in 2016/17).

b) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

c) Scheme provisions

In 2017/18 the NHS pension scheme provided defined benefits, which are summarised below. The list is an illustrative guide only, and is not intended to detail all the benefits provided by the scheme or the specific conditions that must be met before these benefits can be obtained:

Annual Pensions

The annual pension under the 1995 section of the scheme is based on 1/80th of the best of the last three years pensionable pay for each year of service and for the 2008 section it is based on 1/60th of reckonable pay per year of membership. Further changes to the scheme came into effect from 1 April 2015, which mean that the scheme is now based on average salary rather than final salary, with an accrual rate of 1/54th.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This is known as pension commutation.

Members who are practitioners as defined by the scheme regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

Pensions Indexation

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and from 2011/12, are based on changes in consumer prices (CPI) in the twelve months ending 30 September in the previous calendar year.

Ill-health retirement

Early payment of a pension, with enhancement in certain circumstances, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity.

Death benefits

A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

1.5 Pension costs (continued)

Additional voluntary contributions (AVCs)
Members can purchase additional service in the NHS pension scheme and contribute to money purchase AVC's run by the scheme's approved providers or by other free standing additional voluntary contribution (FSAVC) providers.

Transfer between funds
Scheme members have the option to transfer their pension between the NHS pension scheme and another scheme when they move into or out of NHS employment.

Preserved benefits
Where a scheme member ceases NHS employment with more than two years service, they can preserve their accrued NHS pension for payment when they reach retirement age.

1.5.1 Alternative pension scheme

From 1 August 2013 (deferred to 1 October 2013), Leeds and York Partnership NHS Foundation Trust offers an alternative pension scheme to all employees who are not eligible to be members of the NHS pension scheme at the Trust. This includes employees who are members of the NHS pension scheme through another role outside of the Trust and those that are not eligible to join the NHS pension scheme.

Every three years all eligible employees are auto-enroled in either the NHS or alternative pension scheme. The auto-enrolment exercise was carried out in October 2016 and following this process, all employees who meet the criteria for the alternative pension scheme are enroled each month on a continuous basis, unless they specifically opt out.

The alternative pension scheme is a defined contribution scheme operated by the National Employment Savings Trust (NEST). Employee and employer contribution rates are a combined minimum of 5% (with a minimum 2% being contributed by the Trust) and from October 2018 the combined contribution rate will be 8% (with a minimum 3% being contributed by the Trust).

1.6 Expenditure on goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.6.1 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Leeds and York Partnership NHS Foundation Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably;

and if any of the following apply:

- the item has cost of at least £5,000;
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

The finance costs of bringing property, plant and equipment into use are not capitalised.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Any lease which does not meet the requirements of IAS 17 are assumed to be operating leases.

1.6.2 Measurement

Valuation

All property, plant and equipment are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Land and buildings used for the Trust's purposes are stated in the Statement of Financial Position at their revalued amounts being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. In accordance with IFRS and NHS policy, a full revaluation is performed at least every five years, with an interim revaluation in the third year after the full revaluation. An impairment review is undertaken in all other years. The Trust believes that this is sufficiently regular to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use;
- Specialised buildings – depreciated replacement cost based on providing a modern equivalent asset;
- Non-operational land and buildings – fair value based on alternative use.

Professional valuations are carried out by the District Valuers of the Revenue and Customs Government Department. These valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation manual. A valuation was last undertaken as at 31 March 2018 and the assets were reviewed for impairment using the Modern Equivalent Asset (MEA) and alternative site methods as appropriate. From 31 March 2018 PFI assets are valued excluding VAT.

Plant and equipment assets were last indexed using the latest available Consumer Price Indices (CPI), being for February 2018, as issued by the Office for National Statistics.

1.6.3 Subsequent expenditure

Expenditure after items of property, plant and equipment have been put into operation, such as repairs and maintenance, is normally charged to the Statement of Comprehensive Income in the period in which it is incurred. In situations where it can be clearly demonstrated that the expenditure has resulted in an increase in the future economic benefits or service potential expected to be obtained from the use of an item of property, plant and equipment, and where the cost can be measured reliably, the expenditure is capitalised as an additional cost of that asset or as a replacement. The carrying amount of the part replaced is de-recognised.

1.6.4 Depreciation

Items of property, plant and equipment are depreciated, using the straight line method, over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Freehold land is considered to have an indefinite life and is not depreciated.

Property, plant and equipment, which has been reclassified as ‘held for sale’ ceases to be depreciated upon reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

The useful economic lives of property, plant and equipment are estimated by Leeds and York Partnership NHS Foundation Trust as follows:

Plant and machinery	
• Short life engineering plant and equipment	5 years
• Medium life engineering plant and equipment	10 years
• Long life engineering plant and equipment	15 years
• Short life medical and other equipment	5 years
• Medium life medical equipment	10 years
• Long life medical equipment	15 years
Transport	
• Vehicles	7 years
Furniture and fittings	
• Furniture	10 years
Information technology	
• Office and IT equipment	5 years
• Mainframe type IT installations	8 years

Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as assessed by the Trust’s professional independent valuers. The assessed lives of the individual building elements may vary. Leaseholds are depreciated over the primary lease term.

Equipment is depreciated on current cost evenly over the estimated life of the asset.

1.6.4 Depreciation (continued)

The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from it. This period is specific to the foundation trust and may be shorter than the physical life of the asset itself.

Assets held under finance leases (including leased land) are depreciated over the shorter of their estimated useful economic lives or the lease period. Where the Trust will, or is reasonably certain to, acquire ownership of the asset at the end of the lease, the asset is depreciated over its useful economic life.

Estimated useful lives and residual values are reviewed each year end, with the effects of any changes recognised on a prospective basis.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

At the end of each reporting period, a transfer is made from the revaluation reserve to the income and expenditure reserve, in respect of the difference between the depreciation expense on the revalued asset and the depreciation expense based on the assets historic cost carrying value.

1.6.5 Revaluation and Impairment

Increases in asset values arising from revaluations are taken to the revaluation reserve except where, and to the extent they, reverse an impairment for the same asset previously recognised in operating expenses. In this case they are recognised in operating income.

Impairments, that arise from a loss of economic benefit or service potential, are charged to operating expenses in the period that they occur. At the period end, a transfer is made from the revaluation reserve to the income and expenditure reserve for the amount of the impairment (or the remaining balance in the revaluation reserve relating to the asset if this is a lower amount).

Decreases in asset values and all other impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter, are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of “other comprehensive income”.

At each reporting period end, the Trust checks whether there is any indication that any of its property, plant or equipment has suffered an impairment loss. If there is an indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount.

1.6.6 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use.

Assets intended for disposal are reclassified as ‘held for sale’ once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms, which are usual and customary for such sales;

- the sale must be highly probable, i.e. management are committed to a plan to sell the asset; an active programme has begun to find a buyer and complete the sale; the asset is being actively marketed at a reasonable price; the sale is expected to be completed within 12 months of the date of classification as ‘held for sale’; and the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their ‘fair value less costs to sell’. Fair value is open market value including alternative uses. Depreciation ceases to be charged and the assets are not revalued, except where the ‘fair value less costs to sell’ falls below the carrying amount.

Assets are de-recognised when all material sale contract conditions have been met. The non-current assets held for sale are identified in note 19.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset in the revaluation reserve is transferred to the income and expenditure reserve.

Property, plant and equipment, which is to be scrapped or demolished, does not qualify for recognition as ‘held for sale’ and instead is retained as an operational asset and the asset’s economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.7 Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial position' by the Trust. The underlying assets are recognised as property, plant and equipment at their fair value. An equivalent financial liability is recognised in accordance with IAS 17.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received (including lifecycle costs);
b) Payment for the PFI asset, comprising finance costs and the repayment of the liability; and
c) Operating lease for the land.

a) Services received

The fair value of service received in the year is recorded under the relevant expenditure heading within operating expenses.

Leeds and York Partnership NHS Foundation Trust has adopted the approach that we incur the lifecycle costs evenly over the contract period as part of the unitary payment. This is due to the nature of the costs involved.

b) PFI assets and finance costs

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at cost to the PFI Provider but then revalued to 'fair value' by the District Valuer in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16. From 31 March 2018, PFI assets are valued

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to "finance costs" within the Statement of Comprehensive Income. Contingent rent due to inflationary increases in the unitary payment is also included in the finance cost.

The minimum lease payments of the finance lease component are split between the repayment of the liability and a finance cost so as to produce a constant rate of finance over the life of the lease. The finance cost for each year is then calculated by applying this finance rate to the opening lease liability for the financial year. The finance cost is recognised in 'finance costs' in the Statement of Comprehensive Income.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as part of the PFI Operating Expenses in the Statement of Comprehensive Income.

c) Operating lease for the land

The land, which the PFI building is built on, is classified as an operating lease in accordance with IAS 17.

Assets contributed by the Trust to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Trusts Statement of Financial Position.

Other assets contributed by the Trust to the operator

Assets contributed, eg cash payments and surplus property, by the Trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

Leeds and York Partnership NHS Foundation Trust did make an initial 'bullet' payment of cash upfront of £5.4m. This was off set against the initial liability (based on the fair value cost of the building less the £5.4m).

1.8 Intangible Assets

1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. The Trust holds software licences as intangible assets. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably. Where internally generated assets are held for service potential, this involves a direct contribution to the delivery of services to the public.

Purchased computer software licences are capitalised as intangible non-current assets where expenditure of at least £5,000 is incurred. They are amortised over the shorter of the term of the licence and their useful economic lives, currently between 3 and 10 years depending on the software licence.

1.8.2 Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an internally generated intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits, eg the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

1.8.3 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. Subsequent intangible assets are measured at fair value. Revaluation gains, losses and impairments are treated in the same manner as for property, plant and equipment, see notes 1.6.2 and 1.6.5.

1.8.4 Amortisation

Intangible assets are amortised on a straight line basis over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Amortisation is recognised in the Statement of Comprehensive Income.

1.9 Inventories

Inventories are valued at the lower of cost and net realisable value, using the first in - first out cost formula. Inventories are identified in note 16. The Trust's inventories do not include drugs, but comprise stationery, oil and other work stores.

1.10 Cash and cash equivalents

Cash and cash equivalents comprise cash in hand, balances with banks and investments. Cash and bank balances are recorded at the current values of these balances in the Trust's cash book. These balances exclude monies held in the Leeds and York Partnership NHS Foundation Trust's bank account belonging to patients (see "third party assets" below). Interest earned on bank accounts is recorded as "interest receivable" in the period to which it relates. Bank charges are recorded as operating expenditure in the periods to which they relate.

1.11 Provisions

Leeds and York Partnership NHS Foundation Trust provides for present legal or constructive obligations that are of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate in real terms. The discount rate for early retirement and injury benefit provisions (both use the HM Treasury's pension discount rate) is 0.1% (0.24% in 2016/17) in real terms. The discount rate for other provisions varies depending on the timing of the liability from -2.42% (up to 5 years), -1.85% (5 - 10 years) and -1.56% over 10 years (in 2016/17 the discount rates were -2.7%, -1.95% and -0.8% respectively).

1.11 Provisions (continued)

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party; the receivable is recorded as an asset, if it is virtually certain that reimbursement will be received and the amount of the receivable can be measured reliably.

Clinical negligence costs

From 1 April 2000, the NHS Litigation Authority (NHSLA) took over full financial responsibility for all Existing Liabilities Scheme (ELS) cases unsettled at that date and from 1 April 2002 all Clinical Negligence Scheme for Trusts (CNST) cases. Provisions for these are included in the accounts of the NHSLA. Although the NHSLA is administratively responsible for all cases from 1 April 2000, the legal liability remains with the Trust.

The NHSLA operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Leeds and York Partnership NHS Foundation Trust does not include any amounts in its accounts relating to these cases. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 25.

Non-clinical risk pooling

Leeds and York Partnership NHS Foundation Trust participates in the Property Expenses Scheme (PES) and the Liabilities to Third Parties Scheme (LTPS). Both are risk pooling schemes under which the Trust pays an annual contribution to the NHSLA and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises; these are the only amounts included in the accounts of the Leeds and York Partnership NHS Foundation Trust.

1.12 Contingencies

Contingent assets, ie assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control, are not recognised as assets, but are disclosed in note 26 where an inflow of economic benefits is probable.

Contingent liabilities are provided for where a transfer of economic benefits is possible. Otherwise, they are not recognised, but are disclosed in note 26 unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control, or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.13 Value added tax (VAT)

Most of the activities of Leeds and York Partnership NHS Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.14 Corporation tax

Leeds and York Partnership NHS Foundation Trust is a Health Service Body within the meaning of s519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for HM Treasury to disapply the exemption in relation to specified activities of a Foundation Trust (s519A (3) to (8) ICTA 1988). Accordingly, the Trust is potentially within the scope of corporation tax in respect of activities, which are not related to, or ancillary to, the provision of healthcare. Until the exemption is disapplied, the foundation trust has no corporation tax liability.

1.15 Foreign exchange

The functional and presentational currency of the Trust is sterling.

Transactions that are denominated in a foreign currency are converted into sterling at the exchange rate ruling on the date of each transaction. Gains and losses that result are taken to the Statement of Comprehensive Income.

1.16 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since Leeds and York Partnership NHS Foundation Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts, note 30, in accordance with the requirements of the HM Treasury FReM.

1.17 Leases

Finance leases

Where substantially all the risks and rewards of ownership of a leased asset are borne by Leeds and York Partnership NHS Foundation Trust, the asset is recorded as property, plant and equipment and a corresponding liability is also recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted by the interest rate implicit in the lease. The implicit rate is that which discounts the minimum lease payments and any unguaranteed residual interest to the fair value of the asset at the inception of the lease.

The asset and liability are recognised as property, plant and equipment at the inception of the lease and de-recognised when the liability is discharged, cancelled or expires.

The annual rental is split between the repayment of the liability and a finance cost so as to produce a constant rate of finance over the life of the lease. The finance cost for each financial year is calculated by applying this finance rate to the opening lease liability for the financial year. The finance cost is recognised in the Statement of Comprehensive Income.

Contingent rentals are recognised as an expense in the period in which they are incurred. The liability is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. Leased land, in the PFI, is treated as an operating lease.

1.18 Public dividend capital (PDC) and PDC dividend

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the original NHS Trust.

HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by Leeds and York Partnership NHS Foundation Trust, is paid over as PDC dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for donated assets and the average daily balance of cash held with the Government Banking Service, the National Loans Fund and PDC receivable/payable. Average relevant net assets are calculated as a simple mean of opening and closing relevant net assets.

In accordance with the requirements laid down by the Secretary of State (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the pre-audit version of the accounts. The dividend is not revised should any adjustment to net assets occur as a result of the audit of the accounts.

1.19 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the Health Service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in the Statement of Comprehensive Income on an accruals basis, including losses, which would have been made good through insurance cover had NHS foundation trust's not been bearing their own risks (with any insurance premiums being included as normal revenue expenditure). Note 31 is compiled directly from the losses and special payments register which is prepared, as per the DH GAM, on an accruals basis (with the exception of provisions for future losses).

1.20 Financial Instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase and sale of non-financial items (such as goods or services), which are entered into in accordance with Leeds and York Partnership NHS Foundation Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs ie, when receipt or delivery of the goods or services is made.

Financial assets and financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policies for leases.

All other financial assets and financial liabilities are recognised when Leeds and York Partnership NHS Foundation Trust becomes a party to the contractual provisions of the instrument.

Derecognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or Leeds and York Partnership NHS Foundation Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and Measurement

Financial assets are categorised as 'loans and receivables' and financial liabilities are classified as ‘other financial liabilities’.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments, which are not quoted in an active market, and are included in current assets.

Leeds and York Partnership NHS Foundation Trust's loans and receivables comprise: current investments, cash at bank and in hand, NHS receivables and other receivables.

Loans and receivables are recognised initially at fair value, net of transaction costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly, the estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Other financial liabilities

Other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly, the estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability. They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities. Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets

At the Statement of Financial Position date, Leeds and York Partnership NHS Foundation Trust assesses whether any financial assets, other than those held at ‘fair value through income and expenditure’ are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset’s carrying amount and the present value of the revised future cash flows discounted at the asset’s original effective interest rate. The loss is recognised in the income and expenditure account and the carrying amount of the asset is reduced through the use of a bad debt provision.

1.21 Accounting standards that have been issued but have not yet been adopted

a) IASB standard and IFRIC interpretations
Under paragraph 30 of IAS 8, entities need to disclose any new IFRSs that are issued but not yet effective and that are likely to impact the entity.

The DH GAM does not require the following Standards and Interpretations to be applied in 2017-18. These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 and IFRS 17 still subject to HM Treasury consideration.

IFRS 9 Financial instruments

Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted

IFRS 15 Revenue from contracts with customers
Aplication required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted

IFRS 16 Leases

Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

'IFRS 17 Insurance contracts
Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRIC 22 Foreign currency transactions and advance consideration
Application required for accounting periods beginning on or after 1 January 2018.

'IFRIC 23 Uncertainty over income tax treatments
Application required for accounting periods beginning on or after 1 January 2019.

b) Government Financial Reporting Manual (FReM) changes
In preparing the DH GAM, the Department of Health must take account of the requirements of the Government FReM issued by HM Treasury. In some cases, where there is a compelling reason, HM Treasury may grant permission not to adopt a change to the FReM in the DH GAM.

c) Other changes
From 2013/14 the exemption applicable to NHS FTs from consolidating NHS charitable funds that they control has been removed. The effect on Leeds and York Partnership NHS Foundation Trust is the need to consider whether charitable fund income, expenditure, assets, liabilities and reserves should be consolidated within the Trusts main accounts. Income and expenditure between the Trust and the charitable fund would be eliminated on consolidation. Further details are included in note 1.25 - Charitable Funds.

1.22 Accounting standards issued that have been adopted early by Leeds and York Partnership NHS Foundation Trust
No new accounting standards or revisions to existing standards have been adopted early in 2017/18.

1.23 Critical accounting judgements and key sources of estimation uncertainty
In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. These estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates as the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised.

1.24 Private patient income cap
Previously, NHS Foundation Trusts were required to disclose private patient income where this exceeded the amount specified. This disclosure is no longer required.

1.25 Charitable funds

Under IAS 27 (revised) Leeds and York Partnership NHS Foundation Trust is required to consolidate any Charitable Funds that meet the definition of a subsidiary contained in the standard. HM Treasury has previously granted dispensation to NHS FT organisations in this respect, however this dispensation ended in 2013/14. Leeds and York Partnership NHS Foundation Trust has therefore considered the need to consolidate Charitable Funds within the main Trust accounts and concluded, although the Trust continues to meet the criteria within the accounting standard, the value of the Charitable Fund is not material and will not therefore be consolidated within the Trusts main accounts.

IAS 27 (revised) also requires specific disclosures to be included in the accounts. The dispensation previously granted did not include the requirement for appropriate disclosure and consequently note 33 - Charitable funds, continues to be included in the Trusts accounts in compliance with these disclosure requirements.

1.26 Transfer of services

Where the Trust transfers a function to, or receives a function from another entity within the Whole of Government Accounts boundary this represents a “machinery of government change” regardless of the mechanism used to effect the combination, eg, statutory merger or purchase of the business.

The Trust will normally account for a machinery of government change as a transfer by absorption. This includes all transfers of functions involving other bodies within the Department of Health’s Resource Accounting Boundary and transfers of functions involving local government bodies.

1.27 Investment in associates

Associate entities are those over which the Trust has the power to exercise a significant influence. Associate entities are recognised in the Trust’s financial statements using the equity method of accounting. The investment is initially recognised at cost. It is increased or decreased subsequently to reflect the Trust’s share of the entity’s profit or loss or other gains and losses (eg revaluation gains on the entity’s property, plant and equipment) following acquisition. It is also reduced when any distribution, eg share dividends are received by the Trust, from the associate.

Associates which are classified as held for sale are measured at the lower of their carrying amount and fair value less costs to sell.

Leeds and York Partnership NHS Foundation Trust is a 25% partner in the Collaborative Procurement Partnership LLP (CPP LLP), with 3 other NHS foundation trusts. The partnership was registered at Companies House on 18 January 2017 and began implementation on 8 November 2017, following a successful tender process to deliver services to the Department of Health from 8 May 2018. For the year ended 31 March 2018 the CPP LLP is transacting based on a reimbursement of cost model for implementation and therefore there is no profit, gross or net assets to note.

Notes to the accounts

2 Operating segments

Leeds and York Partnership NHS Foundation Trust (LYPFT) provides mental health and learning disability services across the city of Leeds. Specialist services, eg, Forensics, Eating Disorders, CAHMS, Liaison and Perinatal, commissioned by NHS England are also provided by LYPFT in Leeds, York and North Yorkshire.

The majority of Trust income (by value) is on a block basis. The Trust contracted with Leeds Clinical Commissioning Groups (CCGs) for 60% of its income (61% in 2016/17). The Trust also had contracts with NHS England, Health Education England and Local Authorities for the provision of clinical services and education training services.

Two operating segments are reported below. The operating segments are care services and hosted services. The hosted services segment includes the Commercial Procurement Collaborative (CPC), Research & Development, and the Northern School of Child & Adolescent Psychotherapy.

The reportable segments are those used by the Trust's Board and management (the 'Chief Operating Decision Maker' as defined in IFRS 8, Operating Segments) to run the business . Segment information is presented on the same basis as that used for internal reporting purposes. The surplus or deficit for each segment is used to inform the Board of Directors on performance and to assist in negotiations with commissioners on the cost and resources needed to maintain services at a level consistent with the need of the population.

Further detail of each directorate can be found in the Annual Report of the Trust.

	Care Services		**Hosted Services**		**Total**	
	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000	**Year ended 31 March 2018 £000**	Year ended 31 March 2017 £000	**Year ended 31 March 2018 £000**	Year ended 31 March 2017 £000
Income by segment						
Income from activities	**131,672**	128,967			**131,672**	128,967
Other operating income	**16,442**	16,976	**8,399**	7,388	**24,841**	24,365
TOTAL INCOME	**148,114**	145,943	**8,399**	7,388	**156,513**	153,332
TOTAL EXPENDITURE	**(139,819)**	(136,724)	**(8,568)**	(7,172)	**(148,387)**	(143,896)
Operating surplus	**8,295**	9,220	**(169)**	216	**8,126**	9,436
Non Operating Income and Expenditure Total	**(4,311)**	(4,248)	**7**	2	**(4,304)**	(4,246)
Surplus/(Deficit) from continuing operations	**3,984**	4,971	**(162)**	219	**3,822**	5,190

a) Income includes £141m (£137m in 2016/17) from NHS organisations (primarily £97m from Leeds CCGs and £28m from NHS England).

b) Expenditure includes employee expenses £107,740k (£106,203k in 2016/17), premises £4,251k (£4,179k in 2016/17), depreciation and amortisation £4,543k (£4,081k in 2016/17) and establishment £1,926k (£1,878k in 2016/17).

3 Revenue from patient care activities

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Clinical Commissioning Groups and NHS England	**122,990**	120,385
Foundation Trusts	**157**	325
Local Authorities	**46**	45
NHS other	**11**	
Non-NHS:		
Income for social care clients	**8,072**	7,897
Other	**396**	315
Total revenue from patient care activities	**131,672**	128,967

Leeds and York Partnership NHS Foundation Trust participates in a pooled budget arrangement with Leeds CCGs and Leeds City Council as a provider of services. As a provider of healthcare services, Leeds and York Partnership NHS Foundation Trust does not make contributions to the pool, but receives funding from the pool to provide some of its services for people with learning disabilities.

All income from patient care activities is classed as commissioner requested services (CRS).

4 Other operating revenue

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Research and development	**1,256**	1,061
Education and training	**4,209**	4,077
Non-patient care services to other bodies	**1,696**	1,297
Sustainability and transformation fund	**2,502**	2,307
Other income:		
Inter NHS Foundation Trust	**2,489**	2,940
Inter NHS Trust	**1,454**	1,362
Inter RAB	**4,471**	4,648
Inter Other WGA bodies	**192**	193
Other (outside WGA)	**5,294**	5,708
Income in respect of staff costs where accounted on gross basis	**1,278**	772
Total Other Operating Revenue	**24,841**	24,365

5 Operating expenses

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Purchase of healthcare from NHS and DHSC bodies	**165**	43
Purchase of healthcare from non-NHS and non-DHSC bodies	**6,635**	4,650
Purchase of social care	**536**	468
Staff and executive directors costs	**107,740**	106,203
Non-executive directors	**204**	188
Supplies and services – clinical (excluding drugs costs)	**730**	957
Supplies and services - general	**1,515**	1,392
Drugs costs (drugs inventory consumed and purchase of non-inventory drugs)	**2,316**	2,294
Consultancy	**430**	181
Establishment	**1,926**	1,878
Premises - business rates collected by local authorities	**954**	818
Premises - other	**3,297**	3,361
Transport (business travel only)	**971**	1,062
Transport - other (including patient travel)	**557**	602
Depreciation	**4,361**	3,940
Amortisation	**182**	141
Impairments net of (reversals)	**1,557**	(352)
Increase/(decrease) in impairment of receivables	**138**	336
Provisions arising / released in year	**(59)**	2,150
Change in provisions discount rate	**16**	131
Audit services - statutory audit	**59**	60
Other auditor remuneration (payable to external auditor only)	**10**	16
Internal audit - non-staff	**91**	87
Clinical negligence - amounts payable to NHS Resolution (premium)	**260**	217
Legal fees	**287**	511
Insurance	**225**	260
Research and development - non-staff	**1,416**	1,261
Education and training - non-staff	**1,111**	944
Education and training - notional expenditure funded from apprenticeship fund	**13**	
Operating lease expenditure (net)	**1,165**	1,266
Early retirements - non-staff	**13**	9
Redundancy costs - non-staff	**239**	
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (eg, PFI / LIFT) on IFRS basis	**7,436**	7,243
Car parking and security	**175**	143
Other losses and special payments - non-staff	**34**	61
Other	**1,681**	1,375
Total operating expenditure	**148,387**	143,896

£6,635k of expenditure categorised as purchase of healthcare from non NHS bodies relates to payments to private sector healthcare providers, (£4,650k in 2016/17).

Charges to operating expenditure for on-SoFP IFRIC 12 schemes (eg, PFI / LIFT) on IFRS basis £7,436k (£7,243k in 2016/17) includes premises cost £356k, operating leases £389k and supplies and services - general £6,691k, previously included under separate headings (2016/17: £324k, £382k and £6,537k respectively).

Details of the Directors' remuneration can be found in Section 2.4 of the annual report.

Notes to the accounts - 5. Operating expenses (continued)

5.1 Auditors remuneration

The Board of Governors appointed KPMG as external auditors of the Foundation Trust for the three year period commencing 1 June 2017, with an option to extend for a further year. The statutory audit fee will be £49k for 2017/18 excluding value added tax. This was the fee for an audit in accordance with the Audit Code issued by Monitor as updated in December 2014. Other audit remuneration was for audit related assurance services relating to the Quality Report £9k (£9k in 2016/17). Other audit remuneration - non-audit services was nil (£5k in 2016/17 relating to screening checks carried out for board members and new appointments).

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Financial Audit	**49**	50
Other audit remuneration - audit related assurance services (Quality report)	**9**	9
Other audit remuneration - non-audit services		5
Total	**58**	64

6 Operating leases

6.1 As lessee

The leases are for buildings, vehicles and other equipment. Building leases include a 5 year lease on Trust headquarters at Thorpe Park (the break clause in the previous 15 year lease was activated and a new 5 year lease agreed from June 2014) and other non specialised properties used for clinical purposes. Vehicle leases are for cars supplied to qualifying staff under a vehicle lease scheme. Other equipment leases are mainly for photocopy equipment in the various Trust properties.

Payments recognised as an expense	**Year ended 31 March 2018 £000**	Year ended 31 March 2017 £000
Minimum lease payments	**1,165**	1,266
Sub-lease payments		
	1,165	1,266

Total future minimum lease payments	**Year ended 31 March 2018 £000**	Year ended 31 March 2017 £000
Not later than one year	**951**	1,062
Between one and five years	**247**	425
After 5 years		
Total	**1,198**	1,487

Notes to the accounts

7 Employee costs and numbers

7.1 Employee costs

	Year Ended 31 March 2018			Year Ended 31 March 2017		
	Total	**Permanently Employed**	**Other**	Total	Permanently Employed	Other
	£000	**£000**	**£000**	£000	£000	£000
Salaries and wages	**84,993**	**75,755**	**9,238**	83,991	75,226	8,764
Social security costs	**8,265**	**8,265**		7,581	7,581	
Employer contributions to NHS pension scheme	**10,535**	**10,535**		10,405	10,405	
Agency staff	**4,470**		**4,470**	4,791		4,791
Employee benefits expense	**108,263**	**94,555**	**13,708**	106,768	93,213	13,555

There were no employee benefits paid in the year ended 2017/18 (£nil in 2016/17)

In addition to the above:		
Charged to capital		
Recharged income	**(523)**	(565)
Total employee costs	**107,740**	106,203

Full details of the Directors' remuneration can be found in section 2.4 of the Annual Report, of which a summarised version is given below.

The disclosures required under the Hutton report can also be found in section 2.4 of the Annual Report.

	Year ended 31 March 2018	Year ended 31 March 2017
Directors' remuneration	**£000**	£000
Aggregate emoluments to Executive Directors	**681**	721
Remuneration of Non-Executive Directors	**204**	188
Pension cost	**97**	103
	982	1,012

Remuneration of Non-Executives include MH Act Managers £70k (£61k in 2016/17).

7.2 Monthly average number of people employed (wte)

	Year Ended 31 March 2018			Year Ended 31 March 2017		
	Total	**Permanently Employed**	**Other**	Total	Permanently Employed	Other
	Number	**Number**	**Number**	Number	Number	Number
Medical and dental	**195**	**169**	**25**	195	161	34
Administration and estates	**610**	**549**	**61**	615	550	65
Healthcare assistants and other support staff	**786**	**553**	**233**	799	583	216
Nursing, midwifery and health visiting staff	**736**	**688**	**48**	735	682	53
Scientific, therapeutic and technical staff	**307**	**278**	**29**	306	275	31
Social care staff	**1**	**1**		2	2	
Total	**2,634**	**2,238**	**396**	2,651	2,252	399

8 Retirements due to ill-health

During 2017/18 there were 2 (4 in 2016/17) early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liability of this ill-health retirement will be £112k (£183k in 2016/17). The cost of this ill-health retirement will be borne by the NHS Business Services Authority - Pensions Division.

9 Better Payment Practice Code

	Year Ended 31 March 2018		Year Ended 31 March 2017	
	Number	**£000**	Number	£000
Total Non-NHS trade invoices paid in the year	**22,739**	**45,232**	22,387	69,939
Total Non-NHS trade invoices paid within target	**21,946**	**43,579**	21,245	68,213
Percentage of Non-NHS trade invoices paid within target	**97%**	**96%**	95%	98%
Total NHS trade invoices paid in the year	**1,104**	**7,416**	1,141	7,278
Total NHS trade invoices paid within target	**1,018**	**6,779**	1,064	7,086
Percentage of NHS trade invoices paid within target	**92%**	**91%**	93%	97%

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

10 Finance Income

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Bank accounts	**136**	130
Total	**136**	130

This figure includes accrued interest of £19k (2016/17 £5k).

11 Other gains and losses

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Gain on disposal of property, plant and equipment	**2**	
Loss on disposal of property, plant and equipment	**(34)**	
Total	**(32)**	

12 Finance costs

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Interest on obligations under finance leases		
Interest on obligations under PFI contracts:		
- main finance cost	**1,933**	2,056
- contingent finance cost	**2,021**	1,874
Total	**3,954**	3,930

13 Intangible assets

2017/18:	Computer software - purchased £000	2016/17:	Computer software - purchased £000
Gross valuation at 1 April 2017	669	Gross valuation at 1 April 2016	601
Additions purchased	270	Additions purchased	282
Disposals other than by sale	(1)	Disposals other than by sale	(165)
Impairments	(16)	Impairments	(25)
Reclassifications	(47)	Reclassifications	127
Revaluation/indexation	(149)	Revaluation/indexation	(151)
Gross valuation at 31 March 2018	**726**	**Gross valuation at 31 March 2017**	669
Accumulated amortisation at 1 April 2017	40	Accumulated amortisation at 1 April 2016	209
Disposals other than by sale	(1)	Disposals other than by sale	(165)
Revaluation	(149)	Revaluation	(177)
Impairments	7	Impairments	32
Charged during the year	182	Charged during the year	141
Accumulated amortisation at 31 March 2018	**79**	**Accumulated amortisation at 31 March 2017**	**40**
Net book value		**Net book value**	
Purchased	647	Purchased	629
Total at 31 March 2018	**647**	**Total at 31 March 2017**	629

Purchased computer software licences are capitalised as intangible fixed assets where expenditure of at least £5k is incurred. They are amortised over the shorter of the term of the licence and their useful economic lives, currently between 3 and 10 years depending on the software licence. The remaining economic life is assessed each year.

Quotations were sought in 2017/18 for the software licences and this led to an impairment charge to operating expenses of £7k (impairment charge of £32k in 2016/17).

Notes to the accounts

14 Property, plant and equipment

2017/18:	Land	Buildings excluding dwellings	Assets under construct and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2017	2,935	43,805	712	910	368	6,482	823	56,035
Additions purchased			870	27	52	511	11	1,471
Additions donated								
Reclassifications		665	(1,026)			408		47
Reclassified as held for sale	(200)	(247)						(447)
Disposals				(69)	(91)	(303)		(463)
Revaluation/indexation (losses)/gains		(3,801)		14	6		29	(3,752)
Impairments	(560)	(4,296)	(1)					(4,857)
Reversal of Impairments								
At 31 March 2018	**2,175**	**36,126**	**555**	**882**	**335**	**7,098**	**863**	**48,034**
Accumulated depreciation at 1 April 2017		218		807	309	3,881	561	5,776
Disposals				(69)	(88)	(269)		(426)
Reclassified as held for sale		(4)						(4)
Revaluation/indexation (losses)/gains		(4,119)		13	4		21	(4,081)
Impairments		1,096						1,096
Reversal of Impairments		(110)						(110)
Charged during the year		3,172		43	19	1,078	49	4,361
Accumulated depreciation at 31 March 2018		**253**		**794**	**244**	**4,690**	**631**	**6,612**
Net book value								
Total at 31 March 2018	**2,175**	**35,873**	**555**	**88**	**91**	**2,408**	**232**	**41,422**
Asset financing								
Owned	2,175	20,768	555	88	91	2,408	232	**26,317**
PFI		15,090						**15,090**
Donated		15						**15**
Total at 31 March 2018	**2,175**	**35,873**	**555**	**88**	**91**	**2,408**	**232**	**41,422**

The latest revaluation of land and buildings was carried out by the Valuation Office with an effective date of 31 March 2018.

Specialist land and buildings in operational use are valued at Depreciated Replacement Cost (DRC), using a Modern Equivalent Asset basis (MEA). The MEA basis includes consideration of modern building techniques, occupancy rates, service delivery output and alternative site as required.

Non specialist land and buildings in operational use are valued at open market value, assuming existing use.

The Foundation Trust's property, plant and equipment are held for service delivery, rather than for cash generating purposes. Consequently, in accordance with the DH GAM, the "value in use" is assumed to be at least equal to the cost of replacing the service potential provided by the asset unless there has been a reduction in service potential. When measuring impairments, the recoverable amount for operational properties is considered to be the value in use rather than the "fair value less costs to sell".

There are no restrictions imposed on the use of donated assets.

Notes to the accounts - 14. Property, plant and equipment (continued)

14.1 Property, plant and equipment - prior year

2016/17:	Land	Buildings excluding dwellings	Assets under construct and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2016	2,935	43,071	920	894	373	5,118	803	54,114
Additions purchased			2,502	12		595	88	3,197
Additions donated								
Reclassifications		1,741	(2,721)			853		(127)
Reclassified as held for sale								
Disposals				(10)	(9)	(84)	(75)	(178)
Revaluation/indexation (losses)/gains		(1,003)		14	4		7	(978)
Impairments		(4)						(4)
Reversal of Impairments			11					11
At 31 March 2017	**2,935**	**43,805**	**712**	**910**	**368**	**6,482**	**823**	**56,035**
Accumulated depreciation at 1 April 2016		217		755	294	3,108	588	4,962
Disposals				(10)	(9)	(84)	(75)	(178)
Reclassified as held for sale								
Revaluation/indexation (losses)/gains		(2,595)		12	3		5	(2,575)
Impairments		62						62
Reversal of Impairments		(435)						(435)
Charged during the year		2,969		50	21	857	43	3,940
Accumulated depreciation at 31 March 2017		**218**		**807**	**309**	**3,881**	**561**	**5,776**
Net book value								
Total at 31 March 2017	**2,935**	**43,587**	**712**	**103**	**59**	**2,601**	**262**	**50,259**
Asset financing								
Owned	2,935	25,504	712	103	59	2,601	262	**32,176**
PFI		18,066						**18,066**
Donated		17						**17**
Total at 31 March 2017	**2,935**	**43,587**	**712**	**103**	**59**	**2,601**	**262**	**50,259**

14.2 Classification of impairments for Parliamentary budgeting purposes

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Abandonment of assets in course of construction	**1**	
Changes in Market Place	**1,687**	98
Reversals of impairments	**(131)**	(450)
At 31 March	**1,557**	(352)

15 Capital commitments

Contracted capital commitments at 31 March not otherwise included in these accounts:

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Property, plant and equipment	**175**	99
Intangibles		
Total	**175**	99

16 Inventories

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Energy, consumables and work in progress	**64**	46
Total	**64**	46
Of which held at net realisable value:	**64**	46

16.1 Inventories recognised in expenses

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Inventories recognised as an expense in the year	**18**	20
Total	**18**	20

Notes to the accounts

17 Trade and other receivables

	Current		Non-current	
	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000	**Year ended 31 March 2018 £000**	Year ended 31 March 2017 £000
Trade Receivables	**953**	1,557		
Accrued Income	**3,096**	2,656		
Provision for the impairment of receivables	**(548)**	(410)		
Prepayments	**1,015**	1,310	**4,324**	3,937
VAT	**570**	645		
Other receivables	**1,631**	1,875		
Total	**6,717**	7,632	**4,324**	3,937

The majority of trade is with Clinical Commissioning Groups (CCGs), as commissioners for NHS patient care services. As CCGs are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

Credit scoring is not applied to other receivables

17.1 Receivables past their due date but not impaired

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
By up to three months	**802**	1,602
By three to six months	**52**	450
Over six months	**133**	440
Total	**987**	2,492

The Trust does not consider the above debtors, past their due date, to be impaired, based on previous trends and experience.

17.2 Provision for impairment of receivables

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Balance at 1 April	**410**	85
Amount written off during the year		(11)
Increase/(decrease) in receivables impaired	**138**	336
Balance at 31 March	**548**	410

The provision for impairment of receivables for the year ended 31 March 2018 has increased after taking all factors into consideration regarding the potential for recovery.

18 Cash and cash equivalents

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Balance at 1 April	**47,737**	45,968
Net change in year	**4,687**	1,769
Balance at 31 March	**52,424**	47,737
Made up of		
Cash with Government Banking Service	**52,318**	620
Commercial banks and cash in hand	**106**	117
Other current investment		47,000
Cash and cash equivalents as in statement of financial position	**52,424**	47,737
Cash and cash equivalents as in statement of cash flows	**52,424**	47,737

The other current investment relates to a fixed term investment for seven days at 0.18% with the National Loans Fund.

19 Non-current assets held for sale

	Property, Plant and Equipment £000
Balance brought forward 1 April 2017	
Plus assets classified as available for sale in the year	**443**
Less Impairment of assets held for sale	**(3)**
Less assets sold in the year	
Balance carried forward 31 March 2018	**440**

At 31 March 2018 there are two buildings held for sale (nil in 2016/17). These are The Cottage at St Mary's House and Springfield Mount. There were no assets held for sale at 31 March 2017.

20 Trade and other payables

	Current	
	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Trade payables	**1,214**	1,647
Amounts due to other related parties		34
Non NHS trade payables - capital	**685**	1,242
Accruals	**5,871**	5,812
Other	**2,508**	3,518
Total	**10,278**	12,253

21 Borrowings

	Current		Non-current	
	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000	**Year ended 31 March 2018 £000**	Year ended 31 March 2017 £000
PFI liabilities	**1,736**	1,602	**21,416**	23,152
Total	**1,736**	1,602	**21,416**	23,152

22 Other liabilities

	Current	
	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Deferred Income	**1,226**	969
Total	**1,226**	969

23 Finance lease obligations

There are no current finance leases in operation.

24 Private Finance Initiative (PFI) contracts

PFI schemes on-Statement of Financial Position

The PFI contract is for the provision of seven mental health units, providing a comprehensive range of mental health services. The estimated capital value of the PFI scheme is £43,778k. The first unit opened in December 2001 and the last unit opened in February 2003. The contract end date is July 2028. The Trust has the right to purchase the units at market value at the end of the contract.

More detail is provided in the PFI accounting policy in note 1.7

Minimum amounts payable under the contract:

Asset financing component	**Gross Payments**		**Present value of payments**	
	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000	**Year ended 31 March 2018 £000**	Year ended 31 March 2017 £000
Not later than one year	**5,557**	5,409	**5,349**	5,207
Later than one year, not later than five years	**22,226**	21,638	**17,988**	17,512
Later than five years	**24,078**	28,850	**14,527**	16,835
Sub total	**51,861**	55,897	**37,864**	39,554
Less: finance cost attributable to future periods	**(28,709)**	(31,143)	**(14,712)**	(14,800)
Total	**23,152**	24,754	**23,152**	24,754

Services component	**Gross Payments**	
	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Not later than one year	**6,540**	6,367
Later than one year, not later than five years	**26,160**	25,467
Later than five years	**28,340**	33,957
Total	**61,040**	65,791

The future services amounts due as at 31 March 2018 reflect an adjustment for the RPI indexation of the unitary payment applied during 2017/18.

The amount charged to operating expenses during the year in respect of services was £6,430k (2016/17 £6,300k).

24.1 Analysis of amounts payable to service concession operator

	Gross Payments	
	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Unitary payment	**13,379**	12,973
Consisting of:		
- Interest charge	**1,933**	2,056
- Repayment of finance lease liability	**1,602**	1,479
- Service element and other charges to operating expenses	**6,819**	6,682
- Capital lifecycle maintenance		
- Revenue lifecycle maintenance	**617**	561
- Contingent rent	**2,021**	1,874
- Addition to lifecycle prepayment	**387**	321
Total	**13,379**	12,973

The addition to lifecycle prepayment relates to a rent free period at the end of the contract £387k (£321k 2016/17). Service element and other charges to operating expenses includes the operating lease payments for the land element of the properties £389k (£382k 2016/17).

25 Provisions

	Current		Non-current	
	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000	**Year ended 31 March 2018 £000**	Year ended 31 March 2017 £000
Pensions relating to other staff	**138**	137	**1,485**	1,565
Legal claims	**140**	86		
Redundancy	**1,499**	1,938		
Other	**315**	571	**476**	476
Total	**2,092**	2,732	**1,961**	2,041

	Pensions relating to other staff £000	**Legal claims £000**	**Redundancy £000**	**Other £000**	**Total £000**
At 1 April 2016	1,656	117	266	818	2,857
Arising during the year	60	75	1,998	358	2,491
Change in discount rate	131				131
Used during the year	(139)	(63)	(82)	(104)	(388)
Reversed unused	(29)	(43)	(244)	(25)	(341)
Unwinding of discount	23				23
At 31 March 2017	1,702	86	1,938	1,047	4,773
At 1 April 2017	1,702	86	1,938	1,047	4,773
Arising during the year	54	141	895	272	1,362
Change in discount rate	16				16
Used during the year	(139)	(38)	(505)		(682)
Reversed unused	(15)	(49)	(829)	(528)	(1,421)
Unwinding of discount	4				4
At 31 March 2018	**1,622**	**140**	**1,499**	**791**	**4,052**
Expected timing of cash flows:					
Between 1 April 2017 and 31 March 2018	138	140	1,499	315	2,092
Between 1 April 2018 and 31 March 2022	552			476	1,028
Thereafter	933				933
TOTAL	**1,623**	**140**	**1,499**	**791**	**4,053**

The pensions provision is in respect of employees who have taken early retirement through injury or prior to 1995. These provisions are calculated using current year payments and GAD tables as issued by the Office for National Statistics. The GAD tables provide an estimate of remaining lives, which the provision is based on. Payments made against the pensions provisions are quarterly to the NHS Business Services Authority Pensions Division. Due to the nature of the other provisions, there is no certainty regarding the timing of payments.

The legal claims provision is in respect of excess payments to NHS Litigation Authority for employers' and public liability claims. NHS Litigation Authority provides estimates of the likely outcome of the case and damages/costs to be paid. The provision is calculated based on these estimates. There is also a provision relating to employment tribunals £70k (£nil 2016/17).

£9,315k is included in the provisions of the NHS Litigation Authority at 31 March 2018 in respect of the clinical negligence liabilities of the Trust (31 March 2017 £800k).

Other provisions comprise the commitment placed on the Trust in ensuring it meets its obligations in respect of dilapidation costs £519k (£519k 2016/17) and for VAT recovered on software £272k (£nil 2016/17). There is no provision in respect of staff legal claims £nil (£528k 2016/17).

The unwinding of discount on the provisions appears as a finance cost on the face of the Statement of Comprehensive Income.

Leeds and York Partnership NHS Foundation Trust has no expected reimbursements for any class of provision made.

26 Contingent liabilities

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Other	**38**	85
Total	**38**	85

Contingent liabilities represent excess payments not provided for on legal cases being dealt with by NHSLA, on the Trust's behalf, (primarily in respect of employer's liability - £38k in 2017/18 and £85k in 2016/17). Due to the nature of the amounts and timing of the cash flows it would be impractical to estimate the value and timings of the amounts and cash flows.

27 Financial Instruments

Leeds and York Partnership NHS Foundation Trust's financial assets are classified either as "loans and receivables" financial assets. All the Trust's financial liabilities are classified as "other liabilities".

Leeds and York Partnership NHS Foundation Trust undertakes active financial risk management to manage its exposure to risk, particularly credit risk and treasury risk. Similar to general risk management, financial risk management requires identifying its sources, measuring it and implementing plans to address them.

27.1 Financial assets - carrying amount

	Loans and receivables £000
Receivables	5,677
Cash at bank and in hand	47,737
Total at 31 March 2017	**53,414**
Receivables	**5,082**
Cash at bank and in hand	**52,424**
Total at 31 March 2018	**57,506**

Ageing of over due receivables included in Financial Assets

Receivables overdue by:	
1-30 days	**646**
31-60 days	**137**
61-90 days	**31**
91-180 days	**75**
Greater than 180 days	**413**
	1,302

27.2 Financial liabilities - carrying amount

	£000
Embedded derivatives	
Payables	10,268
PFI and finance lease obligations	24,754
Provisions under contract	4,773
Total at 31 March 2017	39,795
Embedded derivatives	
Payables	**10,278**
PFI and finance lease obligations	**23,152**
Provisions under contract	**4,053**
Total at 31 March 2018	**37,483**

27.3 Fair values of loans and receivables and other financial liabilities

The fair value of current loans and receivables are considered to be equal to their carrying amounts. There are no non-current loans and receivables.

The fair values of current financial liabilities are considered to be equal to their carrying amounts.

27.4 Financial risk management

IFRS 7 requires disclosure of the role that financial instruments have had during the year in creating or changing the risks a body faces in undertaking its activities. Leeds and York Partnership NHS Foundation Trust's activities are incurred primarily under annual service agreements with local Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. Consequently the Trust's financial risks are relatively small in comparison with commercial entities. The Trust does not use financial instruments to alter or hedge its risk and therefore their importance to the Trust's finances are similarly relatively low.

Credit risk

This is the risk that other parties may not pay amounts that are due from them to Leeds and York Partnership NHS Foundation Trust. The majority of the Trust's income comes from contracts with other public sector bodies, however, and therefore the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2018 are in receivables from customers, as disclosed in the Trade and other receivables note.

Leeds and York Partnership NHS Foundation Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Board of Directors. The Trust mitigates the risks surrounding treasury management by investing in low risk banks/government backed investors. Trust treasury activity is subject to review by the Trust's internal auditors.

Liquidity risk

Leeds and York Partnership NHS Foundation Trust's net operating costs are incurred primarily under annual service agreements with local Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. Leeds and York Partnership NHS Foundation Trust also largely finances its capital expenditure from funds generated through operating surpluses. Consequently, the Trust is not considered to be exposed to significant liquidity risks (the inability of paying financial liabilities).

Leeds and York Partnership NHS Foundation Trust's main long term liability is its PFI obligation, with the contract ending in 2028. Further information on the commitments under this contract are provided in note 24.

Market risk

Market risk comprises three elements: foreign currency risk, interest rate risk and price risk.

Foreign currency risk

This is the risk that Leeds and York Partnership NHS Foundation Trust's income and expenditure could be affected materially by foreign exchange gains and losses on foreign currency transactions. However the Trust has no foreign currency income and negligible foreign currency expenditure. Consequently, exposure to currency risk is not significant.

Interest rate risk

This is the risk that Leeds and York Partnership NHS Foundation Trust's income and expenditure could be materially affected by changes in interest rates on financial liabilities, e.g. borrowing and financial assets. However, a high percentage of the Trust's financial assets and a high percentage of its financial liabilities carry nil or fixed rates of interest. Leeds and York Partnership NHS Foundation Trust is not, therefore, exposed to significant interest-rate risk.

Price risk

As explained in note 24, Leeds and York Partnership NHS Foundation Trusts' annual unitary payment under its PFI scheme is subject to annual indexation in line with the RPIX. The Trust is therefore exposed to pricing risk in this regard. The annual adjustments are reflected in finance costs (contingent rent), operating expenses and property, plant and equipment additions respectively.

For 2017/18 the percentage increase in the unitary payment was 2.72%, equalling a monetary increase of £208k (1.34%, £47k in 2016/17).

The table below shows a sensitivity analysis of the impact on cash payments and on the surplus/deficit for the year if the uplift had been between 3.7% and 5.5%.

2017/18 Uplift in unitary payment	**Actual uplift at 2.72% £000**	**Uplift at 3.7% £000**	**Uplift at 5.5% £000**
Recognised in finance costs	24	77	174
Recognised in operating expenses	184	250	371
Recognised in surplus/deficit	208	327	545
	208	327	545
Net impact of sensitivities on surplus/(deficit)		**(119)**	**(337)**

2016/17 Uplift in unitary payment	**Actual uplift at 1.34% £000**	**Uplift at 3.7% £000**	**Uplift at 5.5% £000**
Recognised in finance costs	(42)	84	180
Recognised in operating expenses	89	246	366
Recognised in surplus/deficit	47	330	546
	47	330	546
Net impact of sensitivities on surplus/(deficit)		**(283)**	**(499)**

28 Related party transactions - senior employees

During the year Leeds and York Partnership NHS Foundation Trust had the following material transactions with entities which are considered related parties to senior employees (in posts of influence) of the Trust.

	Payments to Related Parties	Receipts from Related Parties	Amounts owed to Related Parties	Amounts due from Related Parties
	£000	**£000**	**£000**	**£000**
University of York	**132**	**3**	**90**	
Royal College of Psychiatrists (2017/18)	**18**			
PATH Yorkshire (2017/18)	**23**			
Carers Leeds (2017/18)		**150**		
MIND (2016/17)	49		2	
Royal College of Psychiatrists (2016/17)	16			
PATH Yorkshire (2016/17)	90		10	
Carers Leeds (2016/17)		149		6

The related party with MIND (2016/17) is no longer considered a related party.

28.1 Related party transactions - members of the Board of Directors

During the year Leeds and York Partnership NHS Foundation Trust had the following material transactions with entities, which are considered related parties to members of the Board of Directors of the Trust:

	Payments to Related Parties	Receipts from Related Parties	Amounts owed to Related Parties	Amounts due from Related Parties
	£000	**£000**	**£000**	**£000**
University of Leeds (2017/18)	**110**	**99**		**22**
University of Leeds (2016/17)	312		49	
British Telecom (2016/17)	14			

The Board Member who declared an interest with BT has now left the organisation

In 2017/18, the Trust had £3k of related party transactions with its charitable fund (2016/17 £3k).

28.2 Related party transactions - commitments (year ended 31/3/2019)

	Income
	£000
Leeds Clinical Commissioning Groups	96,796
NHS England	26,421
	123,217

These commitments are material transactions relating to NHS bodies.

The Trust has no expenditure commitments with related parties for the year ending 31 March 2018.

28.3 Related party transactions - UK Government ultimate parent

During the year Leeds and York Partnership NHS Foundation Trust had a significant number of material transactions with entities for which the UK Government is the ultimate parent, and so has control of. The entities with material transactions (income/expenditure over £500k and receivables/payables over £100k) are listed below:

	Income		Expenditure	
	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000	**Year ended 31 March 2018 £000**	Year ended 31 March 2017 £000
NHS England	**28,146**	27,645	**7**	4
NHS Vale of York CCG	**64**	162		
NHS Leeds North CCG	**23,349**	22,615	**65**	51
NHS Leeds South and East CCG	**36,095**	35,264	**0**	25
NHS Leeds West CCG	**37,897**	37,009		
Leeds Teaching Hospitals NHS Trust	**243**	264	**3,563**	3,612
Leeds Community Healthcare	**2,337**	2,239	**202**	118
South West Yorkshire Partnerships NHS Foundation Trust	**549**	575	**291**	293
York Teaching Hospitals NHS Foundation Trust	**60**	113	**145**	162
Tees, Esk & Wear Valleys NHS Foundation Trust	**872**	869	**428**	311
Health Education England	**6,656**	6,305	**25**	15
NHS Property Services			**890**	897
Department of Health	**841**	609		
HM Revenue and Customs (Employers NI only)			**8,265**	7,581
NHS Pensions Agency (Employers contribution)			**10,535**	10,405
Leeds City Council	**67**	175	**679**	595
Total	**137,176**	133,844	**25,095**	24,069

	Receivables		Payables	
	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000	**Year ended 31 March 2018 £000**	Year ended 31 March 2017 £000
NHS England	**1,883**	2,008		90
NHS Scarborough and Ryedale CCG	**1**	382		
NHS Leeds North CCG	**48**	24	**28**	4
Leeds Teaching Hospitals NHS Trust	**45**	77	**571**	490
Leeds Community Healthcare	**243**	203	**86**	46
Central Manchester University Hospitals NHS Foundation Trust				139
Guy's & St Thomas' NHS Foundation Trust	**293**			
York Teaching Hospitals NHS Foundation Trust		18	**147**	129
Tees, Esk & Wear Valleys NHS Foundation Trust	**82**	87	**230**	133
Health Education England	**66**	158	**8**	54
NHS Property Services			**281**	155
Department of Health	**33**	61		
HM Revenue and Customs	**570**	645		1,985
NHS Pensions Agency (Employee and Employers contribution)				34
Leeds City Council		110	**205**	48
Total	**3,264**	3,773	**1,556**	3,307

29 Intra-Government and other balances

	Current receivables £000	**Non-current receivables £000**	**Current payables £000**	**Non-current payables £000**
Balances with other Central Government bodies	570			
Balances with Local Authorities			210	
Balances with NHS bodies	3,547		2,003	
Intra Government balances	**4,117**		**2,213**	
Balances with bodies external to Government	2,600		8,065	
At 31 March 2018	**6,717**		**10,278**	
Balances with other Central Government bodies	645		2,019	
Balances with Local Authorities	137		49	
Balances with NHS bodies	3,922		1,645	
Intra Government balances	**4,704**		**3,713**	
Balances with bodies external to Government	2,928	3,937	8,540	
At 31 March 2017	**7,632**	**3,937**	**12,253**	

Notes to the accounts

30 Third party assets

The Trust held £239k cash and cash equivalents at 31 March 2018 (£226k 2016/17), which relates to monies held on behalf of service users. This has been excluded from the cash and cash equivalents figure reported in the accounts.

31 Losses and special payments

There were 12 cases of losses totalling £3k (34 in 2016/17 totalling £11k) and 19 special payments totalling £31k (30 in 2016/17 totalling £50k) during the year. These amounts are reported on an accruals basis, excluding provisions for future losses.

Losses	**Number**	**Value £000**
Cash - other	7 (4)	0 (0)
Bad debts - other	5 (30)	3 (11)
Total	**12 (34)**	**3 (11)**
Special payments		
Ex-gratia - loss of personal effects	12 (15)	1 (1)
Ex-gratia - personal injury with advice	7 (15)	30 (49)
Ex-gratia - other	0 (0)	0 (0)
Special severance payments	0 (0)	0 (0)
Total	**19 (30)**	**31 (50)**

Figures in brackets relate to 2016/17.

32 Events after the reporting period

There were no events after the reporting period that had an impact on the Trust's 2017/18 accounts (2016/17: none).

33 Charitable Fund

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Income	**3**	14
Expenditure	**(6)**	(10)
Net movement in funds	**(3)**	4
Current assets	**121**	119
Current liabilities	**(12)**	(2)
Total Charitable Funds	**109**	117

The Charitable fund is not consolidated within these accounts but is disclosed in line with IAS 27 (revised).

CONTACT INFORMATION

Leeds and York Partnership NHS Foundation Trust
Trust Headquarters
2150 Century Way
Thorpe Park
Leeds
LS15 8ZB
Tel: 0113 85 55000
Web: www.leedsandyorkpft.nhs.uk

Chief Executive
If you have a comment for the Interim Chief Executive, please contact:
Dr Sara Munro
Chief Executive
Tel: 0113 85 55913
Email: julie.wortley-froggett@nhs.net

Patient Advice and Liaison Services (PALS)
If you need any help or advice about our services, please contact:
Tel: 0800 0525 790 (Freephone)
Email: pals.lypft@nhs.net

Membership
If you are interested in becoming a member of Leeds and York Partnership NHS Foundation Trust please contact:
The Membership Office
Tel: 0113 85 55900
Email: ftmembership.lypft@nhs.net
Web: www.leedsandyorkpft.nhs.uk/membership

Communications
If you have a media enquiry, require further information about our Trust or would like more copies of this report please contact:
The Communications Team
Tel: 0113 85 55977
Email: communications.lypft@nhs.net

Members of the Board of Directors and Council of Governors
Can be contacted by email at the addresses shown on our website at
Web: www.leedsandyorkpft.nhs.uk
alternatively please contact
The Communications Team
Tel: 0113 85 55977
Email: communications.lypft@nhs.net